Industry and Local 338 Welfare Fund

SUMMARY PLAN DESCRIPTION

January 2006

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Dear Participant:

The Board of Trustees is pleased to provide you with this updated booklet describing the benefits available to you under the Industry and Local 338 Welfare Fund (referred to in this booklet as the "Fund" or the "Plan").

These benefits include:

- **Hospital** and **Medical** benefits through Empire BlueCross BlueShield,
- **Prescription drug** benefits through UllicareRx and Medco Health,
- **Dental benefits** through Self Insured Dental Services ("S.I.D.S."),
- **Optical benefits** through National Vision Administrators,
- **Weekly disability benefits** that provide a weekly income for up to 26 weeks if a disability prevents you from working at your customary occupation, and
- **Life insurance and accidental death and dismemberment benefits** ("AD&D") that pay a lump sum to your survivors in the event of your death, or to you in the event of accidental dismemberment.

Active employees and their eligible dependents are eligible for hospital, medical, prescription drug, dental and optical benefits. Active employees only (and not their dependents) are also eligible for weekly disability, life, and AD&D benefits. Limited medical and life insurance coverage is available for eligible retirees.

This booklet describes your benefits, eligibility rules and the procedures for filing claims in everyday language. Please keep this booklet in a convenient place for future reference and share it with your family.

Although this booklet provides essential information about your benefits, this information is only a summary of the terms under which benefits are provided. Additional information concerning your benefits is contained in related documents, such as insurance contracts. If there is ever a conflict between this summary and the plan documents, the applicable plan documents will govern.

If you have any questions about your benefits, please contact the Fund Office.

With our best wishes,

The Board of Trustees

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INDUSTRY AND LOCAL 338 WELFARE FUND

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Your Plan Benefits at a Glance

Hospital/Medical Benefits
Administered by Empire BlueCross BlueShield PPO **For active employees, eligible dependents and eligible retirees under age 65:** See the hospitalization and medical section of this booklet for more details. Generally, though: • For **"in-network"** services, you do not have to satisfy any deductible, pay coinsurance, or be subject to a lifetime maximum, and instead will be responsible for a copay of $15 for most services. • For **"out-of-network"** services, you pay a deductible ($300 per person and $750 per family), and 20% coinsurance for most services (until you reach the Plan's annual out-of-pocket maximum, at which point the Plan starts paying 100% of reasonable and customary charges). You'll also have a lifetime maximum of $1,000,000 per person.
Prescription Drug Benefit
Administered by Ullicare Rx/Medco Health for active employees and eligible dependents: **For medications prescribed by a doctor and provided through the UllicareRx/Medco Health program, you pay a percentage of the cost of each prescription as coinsurance:** • For a prescription filled at a participating retail pharmacy, you pay 15% of the pharmacy's charge for either a generic or brand-name drug (with a minimum coinsurance payment of $5). • For a prescription filled through the Medco Health Home Delivery Pharmacy Service, you pay 10% of the charge for either a generic or a brand-name drug (with a minimum coinsurance payment of $5). You may receive up to a 30-day supply from a participating retail pharmacy and up to a 90-day supply through the home delivery service.

Dental Benefit
Administered by S.I.D.S. for active employees and eligible dependents: • The Plan pays benefits according to a set fee schedule, with a maximum amount for each dental procedure (this schedule is included in the section on dental benefits). If your dentist charges more than the scheduled amount, you pay the difference. • There is a lifetime limit of $2,700 per covered person for orthodontic services.
Optical Benefit
Provided through National Vision Administrators (NVA) for active employees and eligible dependents: The Plan provides both in- and out-of-network benefits: • If you use an in-network provider, you are permitted one exam and one pair of lenses every 12 months, as well as frames from an approved group every 24 months. • If you use an out-of-network provider, you will be entitled to reimbursement for the same services provided on an in-network basis, but reimbursement will be limited to the maximum amount shown in the section on optical benefits.
Weekly Disability Benefit
Administered by Amalgamated Life for active employees only: • Pays a weekly benefit of $240 per week in the event off-the-job disability prevents you from working at your customary job or occupation. • If disability continues, benefits can be paid for up to 26 weeks.
Life Insurance and Accidental Death & Dismemberment Benefits
Provided by Amalgamated Life for active employees and eligible retirees: • Upon the death of an active employee, the Plan pays a lump sum of $15,000 to the employee's designated beneficiary. • Upon the accidental death of an active employee under age 70, the Plan pays an additional $15,000. For accidental dismemberment, the Plan pays up to $15,000, depending on the extent of loss. • Upon the death of an eligible retiree, the Plan pays a $5,000 benefit to the retiree's designated beneficiary.

Eligibility and Participation

Eligibility for Active Employees

Fund coverage is available to (1) individuals who are in a collective bargaining unit represented by Local 338 and who work for employers who contribute to the Fund, and (2) individuals who are employed by the Industry and Local 338 Welfare Fund, Pension Fund or Local 338.

Participation is also available to your "eligible dependents," as defined later in this section.

When Coverage Starts

- Coverage for benefits other than Weekly Disability generally starts on the first day of the month after you complete 30 consecutive days of covered employment. However, if the collective bargaining agreement between your employer and Local 338 has different eligibility rules, those rules will apply.
- Eligibility for the Fund's weekly disability benefit starts as soon as you start working for a Contributing Employer.

Dependent Coverage

Eligibility for coverage for your dependents generally begins on the same date that your coverage starts or, if later, when they first become your dependent. However, coverage will not begin if you don't provide necessary proof of dependent status.

For coverage to take effect as soon as you've qualified, please provide all information requested by the Fund Office and carefully review the materials you receive from the Fund Office—they'll advise what information, if any, is required. If you don't promptly send the required information, coverage will be delayed.

Eligible Dependents

Your eligible dependents include:

- Your spouse.
- Your unmarried dependent children until the end of the calendar year in which they reach age 23.
- Your unmarried children over age 19 who are unable to support themselves because of mental illness, developmental disability, mental retardation or physical handicap, as defined by applicable laws. The incapacity must have started before the child reached age 19, must be certified by a doctor, and may have to be recertified periodically. Initial written proof of the child's disability must be submitted to the Fund Office within 31 days after the child's 19th birthday. Coverage under this extension ends if the dependent child marries or becomes able to earn a living.

When you enroll a dependent you will be asked to provide proof of dependent status—for example, a birth certificate, adoption papers, a marriage certificate, or income tax returns.

Dependent children include your biological children, stepchildren to whose parent you are married and who reside with you and are dependent on you for financial support, children required to be recognized under a Qualified Medical Child Support Order ("QMCSO"), adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption) and children for whom you are the legal guardian and required to provide support. A foster child is not considered a dependent child.

About QMCSOs. A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation, or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. If you, your child, or the child's custodial parent or legal guardian would like a copy of the Plan's written procedures for handling QMCSOs, or if you have any questions about this process, please contact the Fund Office.

Keep Personal Information Up to Date

You must notify the Fund Office promptly if:

- you marry,
- you give birth to or adopt a child,
- you change your address or phone number,
- you are divorced or legally separated,
- someone in your family dies,
- a child reaches age 23 or stops being dependent on you, or
- you want to change your beneficiary.

Retiree Eligibility

You're entitled to retiree benefits if you meet all of the following requirements:

- You were employed by an employer that signed a collective bargaining agreement that required contributions to the Welfare Fund. (Participants of the Fund who are covered under a collective bargaining agreement with Local 182 will not be eligible for retiree coverage until their employer has contributed to the Fund on their behalf for ten (10) years.)
- You retired on or after December 1, 1983 and are receiving a pension from the Industry and Local 338 Pension Fund or from another pension plan in which employees covered by a Local 338 collective bargaining agreement participate, and for which the employer is making welfare contributions for this benefit.
- You are at least age 55.
- Your pension becomes effective no more than 32 days after your last employer permanently stopped contributing to this Plan on your behalf.
- You remained in Covered Employment until you were at least age 55 or you were employed on or before June 30, 1985 in a bargaining unit for which your employer started contributing to the Fund on or before June 30, 1985.

Note that a special rule applies for "reciprocal pensioners," pensioners who qualify for pensions under the Industry and Local 338 Pension Fund's "Reciprocal Pension" rules. In this case, retiree health benefits are available only if the Industry and Local 338 Pension Fund is the "Terminal Plan" under the Reciprocal Pension rules and the participant is at least age 55 and earned at least 15 Pension Credits under the Industry and Local 338 Pension Fund.

If you meet all the requirements described above, then you and your eligible dependents will be entitled to Fund coverage. However, that coverage will end or be limited if any of the following occurs:

- If your pension becomes effective on or after December 1, 1988, your coverage will be cancelled if your last employer stops contributing to the Welfare Fund.
- If either you or your spouse is eligible to receive medical, surgical and/or hospital benefits from a fund or plan other than this Fund that are paid for directly or indirectly by you or your spouse's employer or former employer, coverage provided by this Fund will be secondary to the coverage provided by the other fund.
- Coverage will end if the monthly premium is not paid.
- If you die while retiree coverage is in effect, coverage for your surviving spouse and any dependent children will end.

Changing Coverage

You may add or drop an eligible dependent at any time. The change generally takes effect as of the date the individual became your dependent provided you give notice within 30 days. You will be required to provide a birth or marriage certificate. If you don't provide notice within 30 days, coverage will not take effect until the first of the month after you apply for coverage.

In the case of a newborn child, coverage automatically begins as of the date of birth, but will continue beyond the first 30 days only if you submit the child's birth certificate. If a child is born to an unmarried dependent who is covered by the Plan, the newborn child will be covered for the first 30 days of his or her life. However, since this child is not an eligible dependent under the Plan, coverage will terminate on the 31st day and cannot be extended.

When Coverage Ends

For you. Your coverage ends:

- At the end of the month in which you voluntarily terminate employment. For example, if you quit on April 15, your coverage will end on April 30.
- At the end of the month following the month in which your employment ends due to layoff or leave of absence. For example, if you are laid off on April 15, benefits will terminate on May 31. However, if you become eligible for weekly disability benefits after the layoff, those benefits will continue for up to 28 days even though your other Fund benefits terminate.
- As of the date your employer stops contributing to the Fund, including if your employer fails to make required contributions on time.
- As of the termination date of the most recent collective bargaining agreement between your employer and Teamsters Local 338.
- As of the date the Plan terminates.

In the event of a strike, the Trustees have the sole discretion to continue benefits for up to five weeks. The decision whether to extend coverage during a strike will be made on a case-by-case basis based upon the Trustees' consideration in each case of all of the relevant circumstances, including the financial condition of the Plan.

Reinstatement. If you are reemployed following a termination or layoff, your coverage may be reinstated immediately (instead of after the 30-day waiting period) if you meet one of the following requirements:

- If you were laid off, coverage can resume immediately if you return to work for a Contributing Employer within **two years** of your termination.
- If your employment ended for reasons other than layoff, your coverage can resume immediately if you

return to work for a Contributing Employer within **one year** of your termination.

For your dependents. Coverage for your dependents ends if:

- Your coverage ends,
- They no longer satisfy the definition of "eligible dependent,"
- The Plan cancels coverage for all dependents or changes the requirements to be an eligible dependent, or
- The Plan terminates.

When coverage for you and/or your dependents would otherwise end, you may be able to continue coverage by electing COBRA Continuation Coverage, as described later. In addition, as described below, the Plan has rules for limited extensions of coverage in special situations.

Continuation of Coverage during Certain Absences

Continuation of Coverage during Disability

Coverage can continue for up to **one year** if your employment ends because of disability and you receive disability benefits from the Fund or workers' compensation.

If you have a work-related disability for which you are entitled to workers' compensation benefits, your coverage will be only for services unrelated to the disability. Medical benefits for services related to the disability should be claimed under workers' compensation law.

Family and Medical Leave. If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (the "FMLA"). Under the FMLA you may take up to 12 weeks of unpaid leave for specified family or medical purposes, such as your own

serious medical condition, the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill.

If you take an FMLA leave, your employer must contribute to the Fund on your behalf for your coverage to continue. Contributions must be made for 40 hours per week at the then-current contribution rate.

If you do not return to employment following an FMLA leave during which coverage was provided, you may be required to reimburse your employer for the cost of coverage received during the leave depending on the reasons for your failure to return to work.

Call your employer if you have questions regarding your eligibility for an FMLA leave. Call the Fund Office regarding coverage during such a leave.

If you don't return to work after the end of your FMLA leave, you may be eligible to continue coverage under COBRA, as described later.

Military Leave. If you leave work to enter the U.S. armed forces, your coverage will generally stop at the end of the month following the month in which you leave employment with a Contributing Employer. However, if you are on active military duty for 31 days or less, you will continue to receive health care coverage under the Fund in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). When your coverage ends because of military leave, USERRA permits you to continue health care coverage for you and your dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA coverage, which is described later. In addition, your dependent(s) may be eligible for health care coverage under the federal program TRICARE (which includes the old "CHAMPUS" program). This Plan coordinates its coverage with TRICARE.

If you receive an honorable discharge and return to work for a Contributing Employer within time limits prescribed by USERRA, your eligibility will be reinstated on the day you return to work.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are reemployed following military service; however, it's a good idea for you to notify the Fund Office, too.

Contact your employer if you have questions regarding your military leave. Contact the Fund Office if you have any questions regarding Fund coverage during such a leave.

Continuation of Health Care Coverage under "COBRA"

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that this Plan offer you and your eligible dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the Plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to hospital, medical, prescription, dental and optical benefits, but not to life insurance, AD&D and disability benefits.

The benefits under COBRA are the same benefits as those provided to individuals who are not on continuation coverage. Each individual entitled to coverage as the result of a qualifying event has a right to make his or her own

election of coverage. For example, your spouse or other covered dependent may elect COBRA coverage even if you reject COBRA coverage. In addition, one qualified beneficiary can elect COBRA for others (for example, a parent or legal guardian may elect continuation coverage for a minor child).

Qualifying COBRA Events. The chart below shows when you and your eligible dependents qualify for continued coverage under COBRA, when coverage starts and when it ends.

If You Lose Coverage Because of This Reason (a "Qualifying Event")	These People Would Be Eligible	For COBRA Coverage Up to (measured from the date coverage is lost)
Your employment terminates[1]	You and your covered spouse and children	18 months[2]
Your working hours are reduced	You and your covered spouse and children	18 months[2]
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your covered children	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

[1] For any reason other than gross misconduct (and including military leave and approved leaves granted according to the Family and Medical Leave Act). As noted previously, continued coverage because of a military leave is available for a period of up to 24 months.

[2] Continued coverage for up to 29 months from the date of the initial event may be available to those who are totally disabled within the meaning of Title II or Title XVI of the Social Security Act at the time coverage is lost or to those who become totally disabled within 60 days after that. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided to the Fund within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase from 102% to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the employee or divorce or legal separation.

Newborn Children. If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption, and submit legal proof of your relationship to the child. You may not add a new spouse to your coverage.

Multiple Qualifying Events. If your covered dependents experience more than one qualifying event while COBRA coverage is in effect, they may be eligible for an additional period of continued coverage, *but the total period of COBRA coverage will not exceed a total of 36 months from the date of the first qualifying event*.

For example, if your employment ends, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if you die (a second qualifying event), your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

When your employer must notify the Fund Office. Your employer must notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than 60 days after your loss of coverage due to one of these events. **However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your coverage.**

When you or your beneficiary must notify the Fund Office. As a covered member or eligible dependent, you must provide the Fund Office with timely notice of certain qualifying events. These events include:

- Divorce or legal separation from your spouse.

- A child no longer satisfies the eligibility requirements for coverage.
- A second qualifying event occurs after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status.
- When a qualified beneficiary entitled to receive COBRA coverage for a maximum of 18 months has been determined by the Social Security Administration to be disabled (as long as the disability occurred on or before the start of COBRA coverage or within the first 60 days of COBRA coverage). The qualified beneficiary may be eligible for an 11-month extension of the otherwise applicable 18-month period of coverage, for a total of 29 months of COBRA coverage.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of the five occurrences listed above. Failure to provide this notice in the form and within the timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage. In addition, if benefits are paid on behalf of an individual who is no longer eligible for coverage (such as a former spouse) because you failed to notify the Fund Office that the individual was no longer eligible for coverage, the Fund will hold both the participant and the beneficiary responsible for repaying the benefits.

How to provide notice. Your notice should be sent to:

Fund Manager
Industry and Local 338 Welfare Fund
One Executive Boulevard
Yonkers, New York 10701

Please include the following in your notice:

- Your name,
- The names of your dependents,
- Your Social Security number and the Social Security numbers of your dependents,
- Your address, and
- The nature and date of the occurrence you are reporting to the Fund.

When the notice must be sent. If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage, or a second qualifying event, you must send the notice no later than 60 days after the later of (1) the date of the relevant qualifying event; or (2) the date on which coverage would be lost as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice should be sent no later than 60 days after the later of (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would have lost coverage due to the qualifying event.

If you are providing notice of a Social Security Administration determination that you are ***no longer*** *disabled,* notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled.

The time periods to provide these notices will not begin until you have been informed of the responsibility to provide the notice and these notice procedures through the furnishing of a summary plan description or a general (initial) notice by the Plan.

Who can provide notice. Notice may be provided by the covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, her spouse and her child are all covered by the Plan, and the child ceases to be a dependent under the Plan, a single notice by the spouse would satisfy this requirement.

Keep the Fund informed of Address Changes

- In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Fund Office.

Electing COBRA coverage. The Fund must notify you and/or your eligible dependents of the right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. **You will have 60 days—measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you—to respond if you want to continue coverage.**

When you or your dependents have notified the Fund of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but you are not in fact entitled to COBRA, the Fund will send you a written notice stating the reason why you are not eligible for COBRA. This notice

will be provided within the same timeframe that the Fund is required to provide an election notice.

Paying for COBRA coverage. You have to pay the full cost of continued coverage under COBRA, plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, the Fund charges 150% of the full cost of coverage during the 19th to 29th months of coverage. Your first payment must be made within 45 days after you elect to continue coverage. All subsequent payments will be due on the first day of each month for that month's coverage. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

When COBRA coverage ends. Your continued coverage under COBRA will end if:

- Coverage has continued for the maximum 18, 29 or 36 month period.
- The Plan terminates. If the coverage is replaced, your coverage may continue under the new coverage.
- Your employer or former employer withdraws from the Fund, but offers another plan. In this case, you may continue coverage under the other plan.
- You or your dependent(s) fail to make the necessary payments on time.
- You or a covered dependent becomes covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent becomes entitled to benefits under Medicare.
- You or your dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Full details of COBRA continuation coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

If continuation coverage is terminated before the end of the maximum coverage period, the Fund will send you a written notice as soon as practicable following the determination that continuation coverage will be terminated early. That notice will tell you the date of termination, and your rights, if any, to alternative individual or group coverage.

Consequences of failing to elect COBRA. In considering whether to elect continuation coverage, you should take into account the effect your decision will have on your future rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of continuation coverage under COBRA may help you avoid such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

Your Rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Under the federal law called the Health Insurance Portability and Accountability Act of 1996 (commonly called "HIPAA"), the Fund is required to provide the following rights:

Special enrollment rights. HIPAA requires that plans like ours guarantee that participants and dependents not otherwise enrolled in a plan have special enrollment rights if certain events occur, known as "qualifying circumstances" under HIPAA. Qualifying circumstances include:

- A change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death. Under these circumstances coverage takes effect the first day of the month following the event as long as coverage is requested within 30 days of the applicable event.
- You previously stated in writing that you and/or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:
    - termination of employment,
    - reduction in hours worked,
    - your spouse dies,
    - you and your spouse divorce or legally separate,
    - the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage, or
    - the other plan terminates because the employer (or other sponsor) did not pay the premium when due.

Certificate of Creditable Coverage. When your Fund coverage ends, you and/or your dependents will be provided with a "Certificate of Creditable Coverage." Certificates of Creditable Coverage state the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), and other information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund, including COBRA coverage, ends. The Certificate of Creditable Coverage may reduce any exclusion for pre-existing conditions that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- On your request, within 24 months after your Fund coverage ends,
- When you are entitled to elect COBRA,
- When your coverage terminates, even if you are not entitled to COBRA, and
- When your COBRA coverage ends.

You should retain Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

HIPAA Privacy. This Plan is a covered entity under HIPAA's privacy regulations, which require that the privacy of your personal health information be protected. The Fund's "Notice of Privacy Practices" appears at the end of this Summary Plan Description.

Conversion Privilege

When your Fund coverage ends, you may be entitled to convert benefits, such as medical and life insurance benefits, to individual policies issued by the insurance carriers. You would be required to pay for this coverage. Please contact the Fund Office for additional information.

Hospital and Health Benefit

Empire BlueCross BlueShield

The Empire BlueCross BlueShield PPO Program provides a comprehensive package of hospital and health care benefits, including office visits, lab tests and X-rays, and major surgery and hospital care.

Both in-network ("PPO") and out-of-network ("non-PPO") services are available. You generally pay less when you use in-network services.

Generally, when you receive in-network benefits through Empire, you do not have to file any claim forms. You just need to follow Empire's procedures on receiving benefits, such as providing your ID card or getting preauthorization when required.

If you receive out-of-network services, you will be required to submit a claim form, unless your provider agrees to do this for you. Again, you will need to follow Empire's procedures on this.

A detailed description of these benefits from Empire BlueCross BlueShield follows.

Your PPO—A Smart Way to Get Health Care

Your PPO, or Preferred Provider Organization, is a group health care plan available to you through an arrangement administered by Empire BlueCross BlueShield. The PPO offers a network of health care providers available to you through Empire. If you think about your town, it includes doctors, hospitals, laboratories, and other medical facilities that provide health care services—that is what we mean by health care "providers." Some health care providers contract with health plans like Empire BlueCross BlueShield to provide services to members as part of the plan's "network."

With Empire's PPO, when you need health care services, you have a choice. Depending on the health care service you need, you are free to get care from providers participating in your PPO network or you can choose to use outside providers. You are covered for medically necessary services no matter which you choose.

What's the Empire PPO Advantage?

When you use Empire's PPO network to access health care, you get:

- A comprehensive Web site, *www.empireblue.com*, for fast, personalized, secure information,
- Among the largest network of doctors and hospitals in New York State,
- Providers that are continuously reviewed for Empire's high standards of quality,
- The ability to choose in-network or out-of-network care for most covered services,
- Minimal out-of-pocket costs for preventive care, behavioral health care and a wide variety of hospital and medical services when you stay in-network,
- Easy to use—no claim forms to file when you stay in-network,
- Coverage for you and your family when traveling or temporarily living outside of Empire's service area.

Manage Your Health Care Online!

Register Now To Do It on the Web!

Go to *www.empireblue.com* where you can securely manage your health plan 24 hours a day, 7 days a week. Here's what you can do:

- Check and resolve claims,
- Search for doctors and specialists,
- Update your member profile,
- Print plan documents, and

- Receive information through your personal "Message Center."

Plus much more.

Here's What You Will Need To Do

All members of your family 18 or older must register separately:

- Go to *www.empireblue.com*, and
- Follow the simple registration instructions.

Assistance Is a Click Away

Use the Click-to-Talk feature to contact Empire three different ways:

E-mail: You can e-mail Empire with a question 24 hours a day, 7 days a week, and a customer service representative will e-mail an answer back to you through your Message Center.

Collaboration: An Empire representative will call you while you are online and navigate the site along with you. Empire can even take control of your mouse, making it easier to answer your questions.

Call Back: You can request that a representative contact you with assistance.

Get Personalized Health Information—Including Your Health IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:

- Take the *Health IQ* test and compare your score to others in your age group,
- Find out how to improve your score—*and your health*—online,

- Find out how to take action against chronic and serious illnesses, and
- Get health information for you and your family.

Your Privacy Is Protected

Your information is protected by one of the most advanced security methods available.

Getting Answers Your Way

Empire gives you choices for contacting them with your customer service questions. Use the Internet, phone, or mail to get the information you need, when you need it.

On the Internet

Do you have customer service inquiries and need an instant response? Visit *www.empireblue.com*.

Empire understands that getting answers quickly is important to you. Most benefit, claims, or membership questions can be addressed online quickly, simply and confidentially.

Nervous about using your PC for important health care questions or transactions? Empire addressed that too! Just "click to talk" to a representative or send an e-mail.

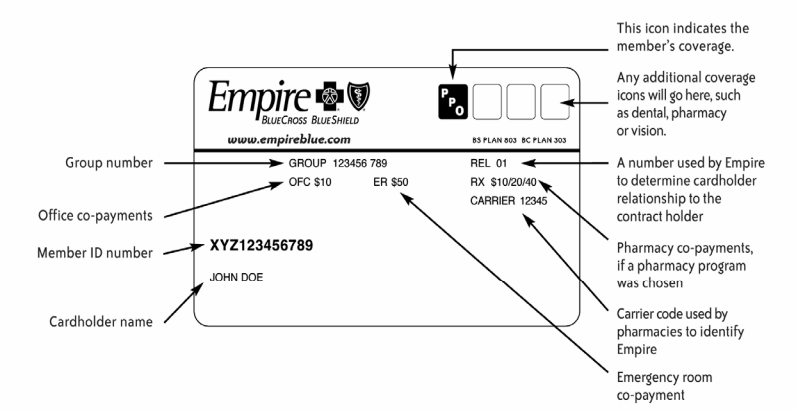
By Telephone

What	Why	Where
Member Services	For questions about your benefits, claims or membership	**1-800-553-9603** TDD for hearing impaired: **1-800-241-6895** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT Servicios Para Idiomas Extranjeros	Si usted no habla inglés	**1-800-553-9603** Por favor permanesca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor. 9:00 a.m. a 5:00 p.m. de Lunes—Viernes
Bluecard® PPO Program	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** ***www.bcbs.com*** 24 hours a day, 7 days a week
Medical Management Program	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	**1-800-553-9603** 8:30 a.m. to 5:00 p.m. Monday -– Friday
Empire Healthline℠	Speak with a specially trained nurse to get health information	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
Fraud Hotline	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

Empire BlueCross BlueShield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Your Identification Card

Empire has created an identification card to make accessing your health care as easy as possible. The Empire BlueCross BlueShield I.D. card is a single card that you can use for all your Empire health care services. Always carry it and show it each time you receive health care services. Every covered member of your family will get their own card.



To make it easier for you to use your new card, following are answers to some frequently asked questions:

Question	Answer
Why is Empire issuing this kind of I.D. card?	Empire's new card has all the information providers need to know to serve our members' health care needs. The new design eliminates the need for you to carry multiple cards.
What do the icons in the upper right hand corner of the card mean?	The icons are illustrations of the plan(s) that you have enrolled in. The first icon shows that you are enrolled in the PPO. The other icons show any additional plans or programs you are enrolled in. It is easy to see what coverage you have!
Why does each family member get a separate I.D. card?	By giving your family members their own card with their own name on it, providers know right away that each family member is covered by the plan—even dependents. If someone in your family happens to forget the card, he or she can still use another family member's card. (In a few instances, family members in some groups will receive two I.D. cards in the member's name only. These cards will be used for all family members.)
How can I replace a lost I.D. card?	Visit *www.empireblue.com* or call Member Services. By visiting Empire on-line, you can also print a temporary identification card for your immediate use.

Using Your PPO

Your health is valuable. Knowing how to use your PPO to your best advantage will help ensure that you receive high quality health care—with maximum benefits. Here are three ways to get the most from your coverage.

- **Be sure you know what's covered by the Plan.** That way, you and your doctor are better able to make decisions about your health care. Empire will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the Plan applies to certain types of care.
- **Please remember to precertify** hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.
- **Ask questions** about your health care options and coverage. To find answers, you can:
  - Read this Guide.
  - Call Member Services when you have questions about your PPO benefits in general or your benefits for a specific medical service or supply.
  - Call Empire HealthLine℠—available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss health care options and more.

Talk to your provider about your care, learn about your benefits and your options, and ask questions. Empire is there to work with you and your provider to see that you get the best benefits while receiving the quality health care you need.

Know the Basics

The key to using your PPO Plan is understanding how benefits are paid. Start by choosing in-network or out-of-network services any time you need health care. Your choice determines the level of benefits you will receive.

You can view and print up-to-date information about your Plan or request that information be mailed to you by visiting *www.empireblue.com*.

Choosing In-Network or Out-of-Network Services

In-network services are health care services provided by a doctor, hospital or health care facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to PPO members. When you choose in-network care, you get these advantages:

- **Choice:** You can choose any participating provider from the largest network of doctors and hospitals in New York State or the national network of Blue Cross and Blue Shield PPO plans.
- **Freedom:** You do not need a referral to see a specialist, so you direct your care.
- **Low Cost:** Benefits are paid after a small copayment for office visits and many other services.
- **Broad Coverage:** Benefits are available for a broad range of health care services, including visits to specialists, physical therapy, and home health care.
- **Convenience:** Usually there are no claim forms to file.

Out-of-network services are health care services provided by a licensed provider outside Empire's PPO network or the PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:

- You pay an annual deductible and coinsurance, plus any amount above the allowed amount (the maximum Empire will pay for a covered service),
- You will usually have to pay the provider when you receive care, and
- You will need to file a claim to be reimbursed by Empire.

Here's an example of how costs compare for in-network and out-of-network care.

	In-Network	Out-of-Network
Provider's Charge	$500	$500
Allowed Amount	$400	$400
Plan Pays Provider	$385	$320 (80% of allowed amount)
You Pay Provider	$15 copayment	$180 (20% of allowed amount, plus the $100 above the allowed amount. Assumes you have satisfied your deductible.)

The following chart shows your specific plan information. See the Details and Definitions section for explanations of terms in the chart.

	In-Network	Out-of-Network
Annual Deductible*	$0	$300/Individual—$750/Family
Copayment (for office visits and certain covered services)	$15 per visit	N/A
Copayment (for hospital inpatient admissions)	$0	N/A
Copayment (for emergency room)	$50 per visit (waived if admitted to hospital within 24 hours)	$50 per visit (waived if admitted to hospital within 24 hours)
Coinsurance	$0	You pay 20% of allowed amount Plan pays 80% of allowed amount
Annual Out-of-Pocket Coinsurance Maximum	N/A	$2,000/Individual—$5,000/Family
Lifetime Maximum	Unlimited	$1 million per person

Where to Find Network Providers

Empire's PPO network gives you access to providers within the Plan's operating area of 28 eastern New York State counties. See "operating area" in the "Details and Definitions" section for a listing of counties.

To locate a provider in Empire's operating area, visit *www.empireblue.com*. You can search for providers by name, address, language spoken, specialty and hospital

* If you had group coverage under a major medical or extended medical plan with Empire prior to your PPO effective date, Empire will apply any deductible met under that prior contract in the same calendar year to your PPO deductible. For services rendered in October, November or December, deductible credit will be applied to the following year's deductible.

affiliation. The search results include a map and directions to the provider's office. Or request that Empire's PPO Directory be mailed to you free of charge by calling Member Services at 1-800-553-9603.

Your PPO Benefits Out-of-Area

When you live or travel outside Empire's operating area, Empire's PPO provides benefits through the following programs.

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other health care providers. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit *www.bcbs.com* to locate participating providers.

BlueCard® Program

The BlueCard Program is available whenever you travel in the United States. Simply show your Empire I.D. card, and you will benefit from discounts that participating providers have agreed to extend to their local Blue Cross and/or Blue Shield plan.

BlueCard® Worldwide

Need emergency services when traveling outside the United States? The BlueCard Worldwide program provides coverage through an international network of hospitals, doctors and other health care providers. With this program, you're assured of receiving care from licensed health care professionals. The program also assures that at least one

staff member at the hospital will speak English, or the program will provide translation assistance.

See the “Details and Definitions” section for more information on the BlueCard and BlueCard Worldwide programs.

Your PPO Benefits at a Glance

Empire’s PPO provides a broad range of benefits to you and your family. Following is a brief overview of your coverage. See the “Coverage” section for more details.

Please don’t forget that certain services require precertification. These services are indicated with a footnote on the following chart.

DOCTOR'S SERVICES (IN OFFICE)	You Pay	
	In-Network	Out-of-Network
Office visits	$15 copay per visit	
Specialist visits	$15 copay per visit	
Chiropractic visits (*maximum of 30 visits per calendar year*)	$15 copay per visit	
Second or third surgical opinion[1]	$15 copay per visit[2]	
Diabetes education and management	$15 copay per visit	
Allergy testing	$15 copay per visit	Deductible and 20% coinsurance
Allergy treatment	$0	
Diagnostic procedures[1]		
• X-rays and other imaging	$0	
• MRIs/MRAs	$0	
• All lab tests	$0	
Surgery	$0	
Chemotherapy	$0	
X-ray, radium and radionuclide therapy	$0	
Second or Third Medical Opinion for Cancer Diagnosis	$15 copay per visit	

[1] Requires precertification.
[2] The copayment is waived if the surgical opinion is arranged through Empire's Medical Management Program.

PREVENTIVE CARE	You Pay	
	In-Network	Out-of-Network
Annual physical exam, one per calendar year	$15 copay per visit	Not covered
Diagnostic Screening Tests		
• Cholesterol: 1 every 2 years	$0	
• Diabetes (if pregnant or considering pregnancy)	$0	
• Colorectal cancer Fecal occult blood test if age 40 or over: 1 per year Sigmoidoscopy if age 40 or over: 1 every 2 years	$0	
• Routine Prostate Specific Antigen (PSA) in asymptomatic males Between ages 40 – 75: 1 every 2 years Over age 75: 1 per year	$0	
• Diagnostic PSA: 1 per year	$0	
• Well-Woman Care		
• Office visits	$15 copay per visit	Deductible and 20% coinsurance
• Pap smears	$0	
• Bone Density testing and treatment	$0	
• Mammogram (based on age and medical history) Ages 35 – 39: 1 baseline Age 40 and older: 1 per year	$0	

PREVENTIVE CARE	You Pay	
	In-Network	Out-of-Network
Well-Child Care • Office visits and associated lab services provided within 5 days of office visit Newborn: 1 in-hospital exam at birth Birth to age 1: 7 visits Ages 1 – 2: 3 visits Ages 3 – 6: 4 visits Ages 7 up to 19th birthday: annual visits	$0	
• Immunizations	$0	

EMERGENCY CARE	You Pay	
	In-Network	Out-of-Network
Emergency Room (requires precertification if admitted)	$50 per visit copay (waived if admitted to the same hospital within 24 hours)	
Physician's Office	$15 copay per visit	Deductible and 20% coinsurance
Air Ambulance[1]—Transportation to nearest acute care hospital for emergency inpatient admissions	$0	You pay the difference between the allowed amount and the total charge.
Ambulance—Local professional ground ambulance to nearest hospital	$0 up to the allowed amount; you pay the difference between the allowed amount and the total charge.	

[1] Requires precertification.

MATERNITY CARE AND INFERTILITY TREATMENT	You Pay	
	In-Network	Out-of-Network
Prenatal and Postnatal Care (in doctor's office)[1]	$0	Deductible and 20% coinsurance
Lab Tests, Sonograms and Other Diagnostic Procedures	$0	
Routine Newborn Nursery Care (in hospital)	$0	
Obstetrical Care (in hospital)[1]	$0	
Infertility Treatment	$0	
Obstetrical Care (in birthing center)[1]	$0	Not covered

[1] Requires precertification.

HOSPITAL SERVICES[1]	You Pay	
	In-Network	Out-of-Network
Anesthesia and Oxygen	$0	Deductible and 20% coinsurance
Blood Work	$0	
Cardiac Rehabilitation	$15 copay per visit	
Chemotherapy and Radiation Therapy	$0	
Diagnostic X-Rays and Lab Tests	$0	
Drugs and Dressings	$0	
General, Special and Critical Nursing Care	$0	
Intensive Care	$0	
Kidney Dialysis	$0	
Pre-Surgical Testing	$0	
Semi-Private Room and Board	$0	
Services of Licensed Physicians and Surgeons	$0	
Surgery (inpatient and outpatient) [2]	$0	

[1] Does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Inpatient admissions and certain outpatient hospital surgeries need to be precertified.

[2] For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES	You Pay	
	In-Network	Out-of-Network
Durable Medical Equipment (i.e., Hospital-type bed, wheelchair, sleep apnea monitor)[1]	$0	Not covered
Orthotics[1]	$0	
Prosthetics (i.e., artificial arms, legs, eyes, ears)[1]	$0	
Medical Supplies (i.e., catheters, oxygen, syringes)	$0	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
Nutritional Supplements (enteral formulas and modified solid food products)[2]	$0	Deductible and 20% coinsurance

SKILLED NURSING AND HOSPICE CARE	You Pay	
	In-Network	Out-of-Network
Skilled Nursing Facility—up to 60 days per calendar year[1]	$0	Not covered
Hospice—up to 210 days per lifetime[1]	$0	

[1] Requires precertification.
[2] $2,500 combined in- and out-of-network limit for modified solid food products in any continuous 12-month period.

HOME HEALTH CARE	You Pay	
	In-Network	Out-of-Network
Up to 200 visits per calendar year (a visit equals 4 hours of care)[1, 2]	$0	20% coinsurance, no deductible
Home infusion therapy	$0	Not covered

PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	You Pay	
	In-Network	Out-of-Network
Physical Therapy and Rehabilitation[1]		
• Up to 90 days of inpatient service per calendar year[2]	$0	Deductible and 20% coinsurance
• Up to 30 visits combined in home, office or outpatient facility per calendar year	$15 copay per visit	Not covered
Occupational, Speech, Vision Therapy[1,3]—up to 30 visits per person combined in home, office or outpatient facility per calendar year	$15 copay per visit	Not covered

1 Requires precertification
2 Treatment maximums are combined for in-network and out-of-network care.
3 Vision therapy does not require precertification.

MENTAL HEALTH CARE	You Pay	
	In-Network	Out-of-Network
Outpatient—up to 50 visits per calendar year*	$15 copay per visit	$15 copay per visit
Inpatient		
• Up to 30 days per calendar year*	20% coinsurance	20% coinsurance
• Up to 30 visits from mental health care professionals per calendar year (*subtracted from the 50 outpatient visits per calendar year*)*	20% coinsurance	20% coinsurance

ALCOHOL OR SUBSTANCE ABUSE TREATMENT	You Pay	
	In-Network	Out-of-Network
Outpatient—up to 60 visits per calendar year, including up to 20 visits for family counseling*	$0	Deductible and 20% coinsurance
Inpatient		
• Detoxification (number of days deducted from the 30 mental health days)*	$0	$0
• Up to 5 days per 15 month period for alcohol		
• Up to 14 days per calendar year for substance abuse		
• Up to 30 days rehabilitation per calendar year *(limit of 2 per lifetime)**	$0	Deductible and 20% coinsurance

* Treatment maximums are combined for in-network and out-of-network care.

Doctor's Services

When you need to visit your doctor or a specialist, Empire makes it easy. In-network, you pay only a small copayment. There are no claim forms to fill out for x-rays, blood tests or other diagnostic procedures—as long as they are requested by the doctor and done in the doctor's office or in a network facility. For in-network allergy testing, there is only a small copayment. In-network visits for ongoing allergy treatment are covered in full.

When you visit an out-of-network physician or use an out-of-network facility for diagnostic procedures, including allergy testing and treatment visits, you pay the deductible and coinsurance, plus any amount above Empire's allowed amount.

Tips for Visiting Your Doctor

- When you make your appointment, confirm that the doctor is an Empire network provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or x-rays, call Member Services to confirm that the supplier is in Empire's network. This will ensure that you receive maximum benefits.

Ask about a second opinion anytime that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury.
- Diabetes supplies prescribed by an authorized provider:
  - blood glucose monitors, including monitors for the legally blind,
  - testing strips,
  - insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices,
  - oral agents for controlling blood sugar,
  - data management systems.
- Diabetes self-management education and diet information, including:
  - education by a physician, certified nurse practitioner or member of their staff:
  - at the time of diagnosis,
  - when the patient's condition changes significantly,
  - when medically necessary.
  - education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate,
  - home visits for education when medically necessary.
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition.

- Diagnosis and treatment for orthognathic surgery that is not a dental condition.
- Medically necessary hearing examinations.
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician.

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain,
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes,
- Orthotics for treatment of routine foot care,
- Routine vision care,
- Routine hearing exams,
- Hearing aids and the examination for their fitting,
- Services such as laboratory, x-ray and imaging, and pharmacy services from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship, and
- Services given by an unlicensed provider or performed outside the scope of the provider's license.

Healthy Living Programs

Preventive Care

Preventive care is an important and valuable part of your health care. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That is why Empire provides many preventive care services for free or for only a small copayment when you use network providers.

For more information on staying healthy, be sure to check the "My Health" section of *www.empireblue.com*. There you will find the latest information on hundreds of topics ranging from nutrition to stress management to children's immunization guidelines.

Tips for Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Get routine mammograms if you are a woman age 35 and over. Frequency of covered services is based on age. Women who have a family history of breast cancer will be covered for a routine mammogram as often as their physician recommends one.
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Well-woman care visits to a gynecologist/obstetrician.
- Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institute of Health for the Detection of Osteoporosis.
- Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institute of Health, including, as consistent with such criteria, dual energy x-ray absorptiometry.
- Coverage shall be available for individuals meeting the criteria of those programs, including one or more of the following:
    - previously diagnosed with or having a family history of osteoporosis,

- symptoms or conditions indicative of the presence or significant risk of osteoporosis,
- prescribed drug regimen posing a significant risk of osteoporosis,
- lifestyle factors to such a degree posing a significant risk of osteoporosis,
- age, gender and/or other physiological characteristics that pose a significant risk for osteoporosis.

➢ Well-child care visits to a pediatrician, nurse, or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. The number of visits covered per year depends on your child's age.

➢ Well-child care immunizations as listed:

- DPT (diphtheria, pertussus and tetanus),
- Polio,
- MMR (measles, mumps and rubella),
- Varicella (chicken pox),
- Hepatitis B Hemophilus,
- Tetanus-diphtheria,
- Pneumococcal,
- Meningococcal Tetramune,
- Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

These preventive care services are not covered:

➢ Screening tests done at your place of work at no cost to you,

- Free screening services offered by a government health department,
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests.

My Health

Empire wants to give you more control over managing your and your family's health. Visit *www.empireblue.com* to access "My Health" and receive personalized information to assist you in maintaining and improving your health.

Here's some of the information you can access from "My Health:"

Assess My Health—calculate your Health IQ. This new online feature measures your health like your IQ measures your intelligence. Use it to find out how you compare to your peers and your level of risk for specific health conditions.

Record My Health—you can safely store, manage, and maintain health information in one secure place; it's accessible anytime, anywhere.

Improve My Health—this interactive health improvement program can help you manage your health concerns such as smoking cessation, fitness and nutrition and pregnancy planning.

Plus, get information about health concerns from A – Z.

Health A – Z is a new feature from My Health that provides fast access to important information on over 150 health topics, such as back and neck pain, cold and flu and anxiety. Just click on any topic and get answers to questions about your and your family's health.

Visit *www.empireblue.com* and register or log on to Online Member Services. From your member home page, click on

"My Health." This will take you to your own personalized health page with interactive features that will enable you to measure and manage your health every day.

For more information or assistance, call Member Services at 1-800-553-9603.

If you become ill and feel that you need urgent or after-hours care, call your provider or Empire HealthLine toll-free, 24 hours a day, seven days a week, at 1-877-TALK2RN (825-5276) for advice from registered nurses.

Healthy Discounts@Empire

Empire members qualify for exclusive discounts on the following additional health and nutritional services through its Healthy Discounts@Empire Program.

Vision Care

Save on laser vision correction, as well as general eye care, including complete eye exams, lenses, frames, and mail order contact lens replacement.*

Wellness Products

Members receive preferred pricing on thousands of quality health and wellness products, including vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products and more.*

* Through arrangements with American Specialty Health Networks, Davis Vision and the International Fitness Club Network, members are entitled to discounts on services rendered by participating providers and practitioners.

These services and products may not be available to all groups and in all states and may not be covered benefits under your Empire health care plan. We make no payment for these value-added programs available to you.

Empire does not endorse or warrant these discounted services and products in any way. We reserve the right to change, amend or withdraw these discount programs at any time without notice to any party.

Alternative Practitioners

Members receive discounts on massage and chiropractic therapy, nutritional counseling and acupuncture through participating alternative practitioners.*

Save Money on Health Club Membership

Show your Empire I.D. card to **receive the lowest rates** currently offered for the type of membership you select **at hundreds of health clubs** nationwide participating in the International Fitness Club Network (IFCN).*

Guest Membership Certificates entitle you and all immediate family members to **one free week** at the network club of your choice. To get your certificate, log on to the IFCN Web site at: *www.ifcn.org*

- Click on "Member's Area,"
- Click on "Free Certificates," and
- Enter "emp" for the first three letters of insurer's name.

For more information, call 1-800-866-8466 (account code 3500).

Save Money While Losing Weight with Weight Watchers®

Show your Empire I.D. card to receive **free registration at Weight Watchers** programs in New York (except Suffolk county), New Jersey (Hudson and Bergen counties) and Connecticut. For more information, call 1-800-651-6000 or visit *www.weightwatchers.com*.

For more information about these services, including information about practitioners, visit *www.empireblue.com* or call Member Services at 1-800-553-9603.

Asthma Management Program

Even the most severe asthmatics can live an active life by learning how to control or prevent an asthma episode. Empire's Asthma Management Program is designed to identify and assist asthmatic members effectively control their asthma.

This program is managed by a team of certified nurse case managers whose primary goal is to assist members in:

- Understanding asthma and its symptoms,
- Controlling the environmental triggers,
- Self monitoring skills,
- Risk factor modification, and
- Creating an action plan to control their asthma.

If you need information on controlling your asthma, call the Asthma Management Program Help Line at 1-800-864-6860. Registered nurses are available 24 hours a day, seven days a week to answer your questions.

Visit *www.empireblue.com* and register or log on to Online Member Services. From your member homepage, click on "My Health." This will take you to your own personalized health page with interactive features that will enable you to measure and manage your health every day.

If you or any of your eligible dependents do not want to participate in the Asthma Management Program, notify Empire in writing at the following address:

Empire Asthma Management
Empire BlueCross BlueShield
P.O. Box 3560
Church Street Station
New York, NY 10008-3560

Please include your Empire ID number, the names and dates of birth of you and your eligible dependents.

Emergency Care

If You Need Emergency Care

Should you need emergency care, your PPO is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy,
- Cause serious problems with your body functions, organs or parts,
- Cause serious disfigurement, or
- In the case of behavioral health, place others or oneself in serious jeopardy.

Sometimes you need medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call Empire HealthLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a copayment for a visit to an emergency room. This copayment is waived if you are admitted to the

hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same copayment as for an office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

If you are admitted to the hospital, you or someone on your behalf must call Empire's Medical Management Program before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from Empire within the required time, a penalty of 50% of benefits will apply.

Tips for Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard® PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room, and if you are admitted, notify Empire's Medical Management Program within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside the United States and visit a hospital which participates in the BlueCard® Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

These emergency services are not covered:

- Use of the Emergency Room:
  - to treat routine ailments,
  - because you have no regular physician, or
  - because it is late at night (and the need for treatment is not sudden and serious).
- Ambulette.

Air Ambulance

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances,

and the use of land transportation would pose an immediate threat to your health.

- Services are covered to transport you from one acute care hospital to another only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health.

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the amount that would be paid for land ambulance to that hospital.

Remember to call Empire's Medical Management Program at 1-800-553-9603 to receive benefits for air ambulance.

Maternity Care and Infertility Treatment

If You Are Having a Baby

There are no out-of-pocket expenses after the initial office visit copayment for maternity and newborn care when you use in-network providers. That means you do not need to pay a copayment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the hospital or birthing center, as well as routine newborn nursery care are all covered 100% in-network.

For out-of-network maternity services, you pay the deductible, coinsurance and any amount above the allowed amount. Empire's reimbursements for the remaining balance may be consolidated in up to three installments, as follows:

- Two payments for prenatal care, and
- One payment for delivery and post-natal care.

Whether services are provided in-network or out-of-network, call Empire's Medical Management Program at 1-800-553-9603 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the Plan for the first 30 days. However, you will need to add the baby's name as a covered dependent within 30 days to add your newborn as a dependent. Call the Fund Office to find about adding your child as a dependent.

Empire BabyCare℠ Program

Empire understands that having a baby is an important and exciting time in your life, so it developed the Empire BabyCare℠ Program. Specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. And, just as important, Empire is available to answer your questions.

While most pregnancies end successfully with a healthy mother and baby, Empire BabyCare is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. Empire can also provide home health care referrals and health education counseling.

Please let Empire know as soon as you know that you are pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in Empire BabyCare. Call 1-800-845-4742 and listen for the prompt that says "precertify." You will be transferred to Empire's BabyCare Program.

Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- One home care visit if the mother leaves earlier than the 48 hour (or 96 hour) limit. The mother must request the visit from the hospital or a home health care agency within this time frame (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later,
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician,
- Parent education, and assistance and training in breast or bottle feeding, if available.
- Circumcision of newborn males,
- Special care for the baby if the baby stays in the hospital longer than the mother does. Call Empire's Medical Management Program to precertify the hospital stay,
- Semi-private room.

These maternity care services are not covered:

- Days in hospital that are not medically necessary (beyond the 48 hour/96 hour limits),
- Services that are not medically necessary,
- Private room,
- Out-of-network birthing center facilities, and
- Private duty nursing.

Use a network obstetrician/gynecologist to receive the lowest cost maternity care.

Infertility Treatment

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations.

Following are covered medical and surgical procedures and services, and limitations:

- Artificial insemination,
- Intrauterine insemination,
- Dilation and curettage (D&C), including any required inpatient or outpatient hospital care that would correct malformation, disease or dysfunction resulting in infertility,
- Services in relation to diagnostic tests and procedures necessary to determine infertility, or in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:
    - hysterosalpingogram,
    - hysteroscopy,
    - endometrial biopsy,
    - laparoscopy,
    - sono-hysterorgram,
    - post-coital tests,
    - testis biopsy,
    - semen analysis,
    - blood tests,
    - ultrasound, and
    - other medically necessary diagnostic tests and procedures, unless excluded by law.

Services must be medically necessary and must be received from eligible providers as determined by Empire. In general, an eligible provider is defined as a health care

provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

For members covered under this group plan, the new contract a member may convert to after termination of coverage may not include infertility benefits.

Hospital Services

If You Visit the Hospital

Your PPO covers most of the cost of your medically necessary care when you stay at a network hospital for surgery or treatment of illness or injury. When you use an out-of-network hospital or facility, you pay the deductible and coinsurance, plus any amount above Empire's allowed amount.

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility,
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Remember to call Empire's Medical Management Program at 1-800-553-9603 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Medical Management within 48

hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to $500 for each hospital admission that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the "Health Management" section for additional information.

If surgery is performed in a network hospital, you will receive in-network benefits for the anesthesiologist, whether or not the anesthesiologist is in the network.

When you use a network hospital, you will not need to file a claim in most cases. When you use an out-of-network hospital, you may need to file a claim.

Tips for Getting Hospital Care

- If your doctor prescribes pre-surgical testing (unlimited visits), have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room.
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient and Outpatient Hospital Care

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services

and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic x-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies,
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration),
- Anesthesiologist, including one consultation before surgery and services during and after surgery,
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia, and
- MRIs/MRAs when pre-approved by Empire's Medical Management Program.

Inpatient Hospital Care

Following are additional covered services for inpatient care:

- Semi-private room and board when the patient is under the care of a physician, and a hospital stay is medically necessary.
- Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified.
- Operating and recovery rooms.
- Special diet and nutritional services while in the hospital.
- Cardiac care unit.
- Services of a licensed physician or surgeon employed by the hospital.
- Care related to surgery.
- Breast cancer surgery (lumpectomy, mastectomy), including:

- reconstruction following surgery,
- surgery on the other breast to produce a symmetrical appearance,
- prostheses,
- treatment of physical complications at any stage of a mastectomy, including lymphedemas.

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.

- Use of cardiographic equipment.
- Drugs, dressings and other medically necessary supplies.
- Social, psychological, and pastoral services.
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery.
- Reconstructive surgery for a functional defect which is present from birth.
- Physical, occupational, speech and vision therapy including facilities, services, supplies, and equipment.
- Facilities, services, supplies and equipment related to medically necessary medical care.

Outpatient Hospital Care

Following are additional covered services for same-day care:

- Same-day and hospital outpatient surgical facilities.
- Surgeons.
- Surgical assistant if:
  - none is available in the hospital or facility where the surgery is performed, and
  - the surgical assistant is not a hospital employee.

- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office, or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
    - at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered),
    - in a hospital-based or free-standing facility. See "hospital/facility" in the Definitions section.

Inpatient Hospital Care Exclusions

These inpatient services are not covered:

- Private duty nursing.
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your deductible or coinsurance.
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life.
- Services performed in the following:
    - nursing or convalescent homes,
    - institutions primarily for rest or for the aged,

- rehabilitation facilities (except for physical therapy),
- spas,
- sanitariums,
- infirmaries at schools, colleges or camps.

- Any part of a hospital stay that is primarily custodial.
- Elective cosmetic surgery or any related complications.
- Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility. See "hospital/facility" in the "Details and Definitions" section.

Outpatient Hospital Care Exclusions

These outpatient services are not covered:

- Same-day surgery not precertified as medically necessary by Empire's Medical Management Program.
- Routine medical care including, but not limited to:
  - inoculation or vaccination
  - drug administration or injection, excluding chemotherapy,
- Collection or storage of your own blood, blood products, semen, or bone marrow.

Durable Medical Equipment and Supplies

If You Need Equipment or Medical Supplies

Your PPO covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from network suppliers only. In-network benefits and plan maximums are shown in "Your PPO Benefits at a Glance" section. Out-of-network benefits are not available.

The network supplier must precertify the rental or purchase by calling Empire's Medical Management Program at 1-800-553-9603. When using a supplier outside Empire's operating area through the BlueCard PPO Program, *you* are responsible for precertifying services. An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

Disposable medical supplies, such as syringes, are covered up to the allowed amount whether you obtain them in- or out-of-network.

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both in- and out-of network. Benefits and plan maximums are shown in "Your PPO Benefits at a Glance" section.

Tip for Obtaining Special Medical Supplies

- For prosthetics, orthotics and durable medical equipment, be sure the network vendor knows the number to call for Medical Management precertification.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
  - artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses,
  - prescription lenses, if organic lens is lacking,
  - supportive devices essential to the use of an artificial limb,
  - corrective braces,

- wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors

- Rental (or purchase when more economical) of medically necessary durable medical equipment,
- Replacement of covered medical equipment because of wear, damage, or change in patient's need, when ordered by a physician,
- Reasonable cost of repairs and maintenance for covered medical equipment,
- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
  - the formula is medically necessary and effective, and
  - without the formula, the patient would become malnourished, suffer from serious physical disorders or die
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed health care provider must provide a written order.

The following equipment is not covered:

- Air conditioners or purifiers,
- Humidifiers or dehumidifiers,
- Exercise equipment,
- Swimming pools,
- False teeth, and
- Hearing aids.

If You Need Skilled Nursing or Hospice Care

You receive coverage through Empire's PPO for inpatient care in a skilled nursing facility or hospice. Benefits are available for network facilities only. Benefits and plan maximums are shown in "Your PPO Benefits at a Glance" section.

In order to receive maximum benefits, please call 1-800-553-9603 to precertify skilled nursing and hospice care with Empire's Medical Management Program.

Skilled Nursing Care

You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in "Your PPO Benefits at a Glance" section. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
  - a referral and written treatment plan,
  - a projected length of stay,
  - an explanation of the services the patient needs, and
  - the intended benefits of care.
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other health care professional.

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
  - gives assistance with daily living activities,
  - is for rest or for the aged,

- treats drug addiction or alcoholism.

- Convalescent care.
- Sanitarium-type care.
- Rest cures.

Hospice Care

Empire's PPO covers up to 210 days of hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Hospice care services, including:
  - up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN),
  - medical care given by the hospice doctor,
  - drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference,
  - physical, occupational, speech and respiratory therapy when required for control of symptoms,
  - laboratory tests, x-rays, chemotherapy and radiation therapy,
  - social and counseling services for the patient's family, including bereavement counseling visits until one year after death,

- transportation between home and hospice when medically necessary,
- medical supplies and rental of durable medical equipment,
- up to 14 hours of respite care in any week.

Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or case worker to see the Health Facilities directory.
- Empire's Medical Management Program will help direct you to a skilled nursing facility that provides the appropriate care. When selecting from among multiple facilities, you may want to consider:

  Is the facility's location convenient to friends, relatives and doctors?

  What size facility is most suitable? A large facility may have more activities; a smaller one may be more personal.

  Are visiting hours convenient for friends and relatives?

  Who directs your care? Does your doctor have privileges at the facility?
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

If You Need Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage when you use an in-network provider. For

out-of-network home health care, you pay coinsurance only (the deductible does not apply). Out-of-network agencies must be certified by New York State or have comparable certification from another state. Benefits and plan maximums are shown in "Your PPO Benefits at a Glance" section.

Remember, in order to receive maximum benefits, you need to precertify home health care through Empire's Medical Management Program. If you use a home health care agency in the Empire network, the agency is responsible for calling Medical Management. If you use a home health care agency in the BlueCard PPO network or out-of-network, *you* need to call Medical Management. (The agency can call for you; however, you need to ensure that they call.)

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. If you use an Empire network home infusion supplier, the supplier must call Medical Management for precertification. While a BlueCard PPO supplier can call to precertify your treatment, you need to ensure that they call.

An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Up to 200 precertified home health care visits per year, combined in- and out-of-network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:

- part-time services by a registered nurse (RN) or licensed practical nurse (LPN),
- part-time home health aide services (skilled nursing care),
- physical, speech or occupational therapy, if restorative,
- medications, medical equipment and supplies prescribed by a doctor,
- laboratory tests.

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care.
- Out-of-network home infusion therapy.

Physical, Occupational, Speech or Vision Therapy

If You Need Therapy

You receive benefits through Empire's PPO for physical, occupational, speech and vision therapy. Outpatient physical, occupational, speech and vision therapy services are available in-network only. Inpatient physical therapy can be in-network or out-of-network.

Please call Empire's Medical Management Program at 1-800-553-9603 to precertify all physical, occupational, and speech therapy. This will ensure that you receive maximum benefits.

Tip for Receiving Therapy

- Ask for exercises you can do at home that will help you get better faster.

Covered services are listed in "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations:

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the plan maximums if:
  - prescribed by a physician,
  - designed to improve or restore physical functioning within a reasonable period of time, and
  - approved by Empire's Medical Management Program.
- Outpatient care must be given at home, in a therapist's office or in an outpatient facility by an in-network provider; inpatient therapy must be short-term.
- Occupational, speech or vision therapy, or any combination of these on an outpatient basis up to the Plan maximums if:
  - prescribed by a physician or in conjunction with a physician's services,
  - given by skilled medical personnel at home, in a therapist's office or in an outpatient facility,
  - performed by a licensed speech/language pathologist or audiologist, and
  - approved by Empire's Medical Management Program, except vision therapy.

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities.
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy.

New Medical Technology

Requesting Coverage

Empire uses a committee composed of Empire Medical Directors, who are doctors, and participating network physicians to continuously evaluate new medical technology that has not yet been designated as a covered service. If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire's Medical Management Program. The provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology.
- Explain how standard medical treatment has been ineffective or would be medically inappropriate.
- Send us scientific peer-reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.

Empire's staff will evaluate the proposal in light of your Plan and Empire's current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer review articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to the member and/or provider.

Behavioral Health Care

If You Need Behavioral Health Care

Empire realizes that your mental health is as important as your physical health. That is why Empire includes behavioral health care benefits at little out-of-pocket cost.

Your behavioral health care benefits cover outpatient treatment for alcohol or substance abuse both in-network and out-of-network, and inpatient detoxification in-network and out-of-network. Inpatient alcohol and substance abuse rehabilitation in a facility is covered in-network and out-of-network. Mental health care is covered on an inpatient basis in-network and out-of-network and on an outpatient basis in-network and out-of-network.

Please note that, with the exception of outpatient alcohol and substance abuse treatment, the coinsurance that you pay for out-of-network behavioral health care services will not count toward reaching your annual out-of-pocket maximum.

Mental Health Care

In addition to the services listed in "Your PPO Benefits at a Glance" section, the following mental health care services are covered:

- Care from psychiatrists, psychologists or certified social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be certified by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy.
- Electroconvulsive therapy for treatment of mental or behavioral disorders.

The following mental health care services are not covered:

- Out-of-network inpatient mental health care at a facility that is not an acute care general hospital.

Treatment for Alcohol or Substance Abuse

In addition to the services listed in "Your PPO Benefits at a Glance" section, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the Plan may receive one counseling visit per day. Visits for family counseling are deducted from the 60 visits available for outpatient treatment.
- Out-of-network outpatient treatment at a facility that:
  - has New York State certification from the Office of Alcoholism and Substance Abuse Services,
  - is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient's diagnosis.

The following alcohol and substance abuse treatment services are not covered:

- Out-of-network outpatient alcohol or substance abuse treatment at a facility that does not meet Empire's certification requirements as stated previously,
- Care that is not medically necessary,
- Out-of-network inpatient alcohol or substance abuse rehabilitation at a facility that is not an acute care general hospital,
- Out-of-network inpatient detoxification at a facility that is not an acute care general hospital.

Exclusions

In addition to services listed under "What's Not Covered" in the prior sections, your PPO does not cover the following:

Dental Services

Dental services, including but not limited to:

- Cavities and extractions,
- Care of gums,
- Bones supporting the teeth or periodontal abscess,
- Orthodontia,
- False teeth,
- Treatment of TMJ that is dental in nature,
- Orthognathic surgery that is dental in nature.

However, your Plan does cover:

- Surgical removal of impacted teeth, and
- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury.

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
  - experimental or investigative,
  - obsolete or ineffective, and
  - any hospitalization in connection with experimental or investigative treatments.

- "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:
    - not of proven benefit,
    - not generally recognized by the medical community (as reflected in published medical literature).

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Government Services

- Services covered under government programs, except Medicaid or where otherwise noted.
- Government hospital services, except:
  - specific services covered in a special agreement between Empire and a government hospital, and
  - United States Veteran's Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

Home Care

Services performed at home, except for those services specifically noted elsewhere in this SPD as available either at home or as an emergency.

Inappropriate Billing

- Services usually given without charge, even if charges are billed, and
- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified.

Medically Unnecessary Services

Services, treatment or supplies not medically necessary in Empire's judgment. See "Definitions" section for more information.

Miscellaneous

Surgery and/or treatment for gender change.

Prescription Drugs

All prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication, unless specifically indicated.

Sterilization/Reproductive Technologies

- Reversal of sterilization.
- Assisted reproductive technologies including but not limited to:
  - in-vitro fertilization,
  - gamete and zygote intrafallopian tube transfer,
  - intracytoplasmic sperm injection.

Travel

Travel, even if associated with treatment and recommended by a doctor.

Vision Care

Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated.

War

Services for illness or injury received as a result of war.

Workers' Compensation

Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

Limitation as Independent Contractor

The relationship between Empire BlueCross BlueShield and hospitals, facilities or providers is that of independent contractors. Nothing in this SPD or any other documents shall be deemed to create between Empire and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Empire will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

Health Management

Helping You Manage Your Health

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the Plan will pay. To help you manage your health, Empire provides three important services: Medical Management, Case Management and Empire HealthLine℠.

Empire's Medical Management Program

Empire's Medical Management Program is a service that precertifies hospital admissions and certain treatments and procedures to ensure that you receive high quality care for the right length of time, in the right setting, with maximum coverage.

When you call Empire's Medical Management Program, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- Learn more about your health care options,
- Choose the most appropriate health care setting or service (e.g., hospital or same-day surgery unit),
- Avoid unnecessary hospitalization and the associated risks, whenever possible,
- Arrange for any required (and covered) discharge services.

To help ensure that you receive quality care, Empire's Medical Management Program works with you and your provider to:

- Review planned and emergency hospital admissions,
- Review ongoing hospitalization,

- Coordinate purchase and replacement of durable medical equipment, prosthetics and orthotics,
- Review inpatient and same-day surgery,
- Review high risk pregnancies,
- Perform individual case management,
- Review care in a hospice or skilled nursing facility,
- Review home health care and home infusion therapy,
- Coordinate discharge planning.

In most situations, you or someone acting on your behalf needs to call the Medical Management Program to precertify hospital admissions and certain services. In other cases, the vendor or provider of services needs to call. This will ensure you receive maximum benefits.

The following chart shows which health care services must be precertified with Empire's Medical Management Program before you receive them.

Call to Precertify...	How Covered	Who Calls to Precertify
All Hospital Admissions • At least two weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission, or as soon as reasonably possible • For illness or injury to newborns	In-network and Out-of-network	You
Pregnancy • Within the first three months of a pregnancy		

Call to Precertify...	How Covered	Who Calls to Precertify
Before You Receive • Inpatient physical therapy • Same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures • Cardiac rehabilitation • A magnetic resonance imaging or magnetic resonance angiography scan (MRI or MRA)	In-network and Out-of-network	You
Before You Receive • Hospice care • Occupational or speech therapy • Outpatient physical therapy • Skilled nursing facility care • Air ambulance service	In-network only	You
Before You Receive • Home health care services	Empire network	Network Supplier
	Out-of-network or BlueCard PPO network	You
Before You • Receive home infusion therapy	Empire network	Network Supplier
• Rent, purchase or replace prosthetics, orthotics or durable medical equipment	BlueCard PPO network	You

When you call the Medical Management Program to precertify services, you receive maximum benefits and helpful advice about your options.

If Services Are Not Precertified

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $500 for each admission, treatment or procedure. This benefit reduction also applies to same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

Tips for Precertifying Services with Medical Management

- Have the following information about the patient ready when you call:
  - Name, birth date and sex
  - Address and telephone number
  - Empire I.D. card number
  - Name and address of the hospital/facility
  - Name and telephone number of the admitting doctor
  - Reason for admission and nature of the services to be performed
- When the vendor or provider is required to call Empire's Medical Management Program for precertification, be sure they know about the precertification requirement and that they have the Medical Management telephone number.

Initial Decisions

Empire will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services.

- *Precertification Requests.* Precertification means that you must contact Empire's Medical Management Program for approval before you receive certain health care services. We will review all requests for precertification within three (3) business days of receipt of the necessary information but not to exceed 15 calendar days from the receipt of the request. If we

do not have enough information to make a decision within three (3) business days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within three (3) business days of our receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.

- *Urgent Precertification Requests.* If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision, we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- *Concurrent Requests.* Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care. We will complete all concurrent reviews of services within 24 hours of our receipt of the request.
- *Retrospective Requests.* Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within 15 calendar days of our receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

If a Request Is Denied

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See the section entitled "Complaints, Appeals, and Grievances" for more information.

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Case Management

If You Need Additional Support for Serious Illness

The Medical Management Program's Case Management staff can provide assistance and support when you or a member of your family faces a chronic or catastrophic illness or injury. Empire's nurses can help you and your family:

- Find appropriate, cost-effective health care options,
- Reduce medical costs,
- Assure quality medical care.

A Case Manager serves as a single source for patient, provider, and the Fund—assuring that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer,
- Stroke,
- AIDS,

- Chronic illness,
- Hemophilia, and
- Spinal cord and other traumatic injuries.

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire's Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the PPO is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact Empire's Medical Management Program at 1-800-553-9603.

Empire HealthLine℠

Need Health Information or Advice?

Empire understands that part of maintaining your health is having the information you need to make informed decisions, so we have the people and programs in place to help. Questions about your health care? Call Empire HealthLine℠, a round-the-clock information line available free of charge to Empire members. When you call in, you will have the option to either speak to a registered nurse or listen to over 1,100 audiotape messages on a wide variety of topics. If you don't speak English, interpreters are also available through the AT&T Language Line.

When You Should Call

Below are some examples of situations you may find yourself in when the HealthLine can be of assistance to you and your family. This list is by no means complete, so call if you ever find yourself in need of any health advice. The nurses at the HealthLine are here to help you.

Assessing Symptoms

- Your child has a fever of 103 and you are not sure what to do.
- You can't tell if you've sprained or broken your ankle.
- You cut your hand on a piece of glass and are not sure if a trip to the emergency room is necessary.
- You are on vacation and don't know where to go for help with a medical problem.
- You don't know the cause of the rash on your arm.
- You have been feeling sad for weeks and wonder what you should do.

Understanding a Medical Condition, Procedure, Prescription, or Diagnosis

- You need information about a personal health issue such as diet, exercise or high blood pressure.
- You scheduled a cholesterol test but don't fully understand the results.
- You are not sure about the possible side effects of certain medications.
- You have a question about pregnancy.
- You want to know about the signs and symptoms of sexually transmitted diseases.

Discharge from a Hospital

- Your doctor says you need a wheelchair delivered to your home in order to be discharged from the hospital and you need help finding one.
- Your doctor has sent you home with a discharge treatment plan you do not fully understand.

- Information about specific health conditions and procedures.
- More than 1,100 health care topics available in English and Spanish. Refer to the directory at the end of this section for a listing of available topics.

Dialing In

- Dial 1-877-TALK-2RN (825-5276) and follow the prompts to speak with a nurse or to listen to the audio messages.
- If you plan on listening to the tapes, have your member number handy. You will need to enter the first three digits. For example, if your number is YLD123456789, enter YLD (953).
- At the end of this section there is a complete listing of audio message topics. Note the code numbers for the topics that you want to listen to, as you will be prompted for these numbers.
- If you have additional questions after listening to a tape, simply connect to the on-duty nurse.

The Wrong Time to Call

Empire HealthLine^{SM} is NOT for emergencies, so please DO NOT call if you believe you or a family member:

- Is having a heart attack or stroke,
- Is severely injured,
- Is unable to breathe,
- May have ingested poisonous or toxic substances, or
- Is unconscious.

IN THESE CASES, CALL 911 or your local Emergency Service as soon as possible!

Empire HealthLine℠
1-877-TALK-2RN (825-5276)
24 hours a day, 365 days a year

Details and Definitions

In this section, we'll cover the details you need to know to make the Plan work for you. Use it as a reference to understand:

- How to file a claim and get your benefits paid,
- Your rights to appeal a claim payment or Medical Management decision, and
- What we mean by certain health care terms.

Knowing the details can make a difference in how satisfied you are with your PPO, and how easy it is for you to use. If you have additional questions, please visit *www.empireblue.com* or call Member Services at 1-800-553-9603.

Claims

If You Need to File a Claim

Empire's PPO makes health care easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received out-of-network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service.

Type of Claim	In-Network	Out-of-Network
Hospital	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	Provider files claim with Empire or local Blue Cross/Blue Shield plan*
Medical	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire
Ambulance Charges	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire

	Send completed forms to:
Hospital Claims	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attention: Institutional Claims Department
Medical Claims	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attention: Medical Claims Department

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting *www.empireblue.com*.

* At some out-of-area and non-participating hospitals, you may have to pay the hospital's bill. If this happens, include an original itemized hospital bill with your claim.

Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-800-553-9603 to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

File claims within 18 months of the date of service to receive benefits!

Health Care Fraud

Illegal activity adds to everyone's cost for health care. That's why Empire welcomes your help in fighting fraud. If you know of any individuals receiving Empire benefits that they are not entitled to, call us. We will keep your identity confidential. Want to see some recent examples of Empire's fraud prevention efforts? Visit *www.empireblue.com*.

FRAUD HOTLINE
1-800-I-C-FRAUD (423-7283)
During normal business hours

If You Have Questions About a Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your copayment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial,
- References to the pertinent Plan provisions on which the denial is based,
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary,
- An explanation of claims review procedures.

If you have any questions about your claim, the Fund Office may be able to help you answer them. You may also contact Empire Member Services at 1-800-553-9603 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your claim. Send written inquiries to:

Empire BlueCross BlueShield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Quality Assurance

Quality health care is important to you and Empire. In the event that you are less than satisfied with a benefit payment, a coverage decision, or with one of our network providers, there are steps you can take to resolve your concerns.

When you have questions or concerns, you should call Member Services at 1-800-553-9603. In most cases, Member Services will be able to answer your questions. If you are not satisfied, you may file a complaint, grievance or appeal with Empire by phone or by writing to us at:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Appeals Unit

Your Right to Appoint a Representative

You may appoint a representative to act on your behalf if you are not able to submit a complaint, grievance or appeal on your own. Call Member Services for a form. When completed forms are returned, we will note the name of your representative's name in our files.

Provider Quality Assurance

Because your health care is so important, Empire has a Quality Assurance Program designed to ensure that our network providers meet our high standards for care. Through this program, we continually evaluate our network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns

directly with your provider. If you are still not satisfied, you can submit a complaint to Member Services. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

Empire also encourages you to send suggestions to Member Services for improving our policy and procedures. If you have any recommendations on improving our policies and procedures, please send them to the Member Services address on the previous page.

Standard Internal Appeals

An appeal is a request to review and change an adverse determination (i.e., a benefit denial or reduction) made by Empire's Medical Management Program that a service is not medically necessary or is excluded from coverage because it is considered experimental or investigational.

Appeals may be filed by telephone or in writing.

Level 1 Appeals

A Level 1 Appeal is your first request for review of the initial reduction or denial of benefits. You have 180 calendar days from the receipt of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

We will make a decision within the following time frames for Level 1 Appeals.

- *Precertification.* We will complete our review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Concurrent.* We will complete our review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Retrospective.* We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

We will provide a written notice of our determination to you or your representative, and your provider, within two business days of reaching a decision.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.

A Level 1 Appeal submitted beyond the 180-calendar day limit will not be accepted for review. A Level 2 Appeal submitted beyond the 60-business day limit will not be accepted for review.

Expedited Level 1 Appeals

You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue health care services, procedures or treatments that have already started,
- You need additional care during an ongoing course of treatment, or
- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed

without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

- You or your provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request,
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal, and
- Empire will notify you immediately of the decision by telephone, and within 24 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options.

Level 2 Appeals and Time Frames

If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If the appeal is not submitted within that timeframe, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing.

We will make a decision within the following time frames for Level 2 appeals:

- *Precertification.* We will complete our review of a precertification appeal within 15 calendar days of receipt of the appeal.
- *Concurrent.* We will complete our review of a concurrent appeal within 15 calendar days of receipt of the appeal.

- *Retrospective.* We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Level 1 Grievances

A grievance is a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity. For example, a claim was denied because the member did not obtain precertification for services.

A Level 1 Grievance is your first request for review of the initial reduction or denial of benefits. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance.

We will make a decision within the following time frames for Level 1 Grievances:

- *Pre-service (services have not yet been rendered)*. We will complete our review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.
- *Post-service (services have already been rendered)*. We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

Decision on Grievances

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision,
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

Level 2 Grievances

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire within 60 business days from receipt of the notice of the letter denying your Level 1 Grievance. If the Level 2 Grievance is not submitted within that time frame, we will not review it and the decision on the Level 1 Grievance will stand. We will acknowledge receipt of the Level 2 Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

We will make a decision within the following timeframes for Level 2 Grievance:

- *Pre-service*. We will complete our review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- *Post-service*. We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

Expedited Grievances

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum time frames:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within 72 hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

How to File an Appeal or Grievance

To submit an appeal or grievance, call Member Services at 1-800-553-9603, or write to the following address with the reason why you believe the coverage request was improperly denied or the claim was improperly paid. Please submit any data to support your request and include your member I.D. number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire BlueCross BlueShield
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Optional Appeal to the Board of Trustees

If your Level 1 Expedited Appeal, your Level 2 Appeal, your Level 2 Grievance, or your Expedited Grievance is denied in whole or in part, you also have the option of filing an appeal with the Board of Trustees. For more information about this optional appeal, please refer to the "Claims and Appeals" section that appears later in this SPD.

Converting Your Coverage

Under certain circumstances, you may convert your group coverage to individual coverage with comparable benefits if such coverage is available from your group or you may convert your group coverage to a Medicare supplemental policy, if appropriate. However, not all your current benefits may be available when you convert your coverage. Please contact Empire for details.

To request an application or obtain additional information on converting your coverage, call 1-800-261-5962.

If you are converting to a Medicare Supplemental policy, and you live outside New York State, you should contact your local Blue Cross or Blue Shield plan.

Carve-Out Program

If the previously referred conditions do not apply, and the covered person is Medicare eligible, he/she will receive this program's benefits reduced by Medicare's benefits ("carve-out"). This limitation applies even if you or your spouse fail to enroll in Medicare or do not claim the benefits available under Medicare.

Carve-out is a program for some participants who are eligible for Medicare and for whom Medicare is primary. You will receive the same benefits as the non-Medicare members in your group less the amount paid by Medicare. You or your health care provider should file a claim with Medicare, not Empire. After Medicare processes your claim, forward the Medicare EOB to Empire for additional processing.

As a carve-out participant, you must meet the same contractual requirements (e.g., coinsurance, maximum allowances, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible.

Carve-out benefits are not available for a service that is not covered by the Plan.

For Members Who Don't Speak English

Empire will help members who speak languages other than English ask questions and file grievances in their first language. When you call Member Services, the operator will link you to an interpreter in your preferred language, who can facilitate the discussion. Empire HealthLine is also equipped to provide assistance in most languages.

Confidentiality Policy

In recognition of the need for member privacy, and in compliance with applicable law, Empire has a policy on the confidentiality of member medical information.

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and applicable laws concerning the use, disclosure, release, security, storage and destruction of confidential member medical information.
- When you become covered under your Plan, you agree that Empire, or its designee, may use and/or disclose your confidential medical information for purposes of payment and health care operations as permitted or required by law or regulation. In addition, each member agrees that any health care provider, health care payor or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made for use and/or disclosure by Empire to administer the terms of the Plan.
- Disclosure of confidential information to external vendors for purposes of payment or health care operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.

- Identifiable personal health information is not shared with your employer, unless permitted or required by law. Because Empire is not a provider of medical services, it generally does not maintain medical records created by your provider of service. If you require access to your provider's medical records, please contact your provider to arrange access. Empire requires all of its network practitioners and providers to ensure the privacy and to protect the confidentiality of members' medical information.
- You may request access to any other information that is maintained by or for Empire by calling Member Services to arrange access.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release, authorized by the member or member's designee, which may be revoked at any time. The authorization must specify:
    - the information that can be disclosed,
    - what the information will be used for, and
    - the time period for which the authorization applies.

Definitions

Refer to these definitions to help you better understand your Empire PPO coverage. Need more help? Additional terms and definitions can be viewed at *www.empireblue.com*.

Adverse Determination

A communication from Empire's Medical Management that reduces or denies benefits.

Allowed Amount

The maximum Empire will pay for a covered service out-of-network. The allowed amount is based on an agreement between Empire and the provider, or if there is no agreement, then on the customary charge or the average market charge in your geographic area for a similar service. You are responsible for paying the entire portion above the allowed amount.

Ambulatory Surgery

See "same-day surgery."

Annual Out-of-Pocket Coinsurance Maximum

The most you will have to pay in out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the Plan pays 100% of the allowed amount for covered expenses for the remainder of that calendar year. Your copayments, deductible, the coinsurance for behavioral health care expenses, and any amount you pay above the out-of-network allowed amount do not count toward your annual out-of-pocket coinsurance maximum.

Authorized Services

See "precertified services."

BlueCard® Program

The BlueCard Program helps reduce your costs when you obtain out-of-network care outside the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan ("local Blue Plan"). Just show your Empire I.D. card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain health care through the BlueCard Program, the portion of your claim that you are responsible for ("member liability") is, in most instances, based on the **lower** of the following:

- The billed amount that the participating provider actually charges for covered services, or
- The negotiated price that the local Blue Plan passes on to Empire.

Here's an example of a negotiated price and how it benefits you:

A provider's standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, you pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

- A simple discount from the provider's usual charges, which is the amount that would be reimbursed by the local Blue Plan,
- An estimated price that has been adjusted to reflect expected settlements, withholds, any other contingent payment arrangements and any non-claim transactions with the provider, or
- The provider's billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price.

If you have any questions about the BlueCard Program, contact Member Services.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of health care providers. With this program, you're assured of receiving care from licensed health care professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-800-810-BLUE (2583), 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct® Access Number.

Show your Empire I.D. card at the hospital. If you're admitted, you will only have to pay for expenses not covered by the Plan, such as copayments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the health care provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any copayment and amount above the allowed amount.

Coinsurance

When you get care out-of-network, you and your PPO share the cost of covered expenses, after you meet the deductible. For example, if your PPO pays 80% of the allowed amount, you pay 20% plus any costs above the allowed amount. Once your coinsurance expenses reach the

annual out-of-pocket maximum, your PPO will pay 100% of the provider's charge or the allowed amount, whichever is less.

Copayment

The fee you pay for office visits and certain covered services when you use in-network providers. The Plan then pays 100% of remaining covered expenses.

Covered Services

The services for which Empire provides benefits under the terms of the Plan. For example, Empire's PPO covers one in-network annual physical exam.

Deductible

The dollar amount you must pay each calendar year before your PPO pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, your PPO will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit—if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

Hospital/Facility

A fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies.

- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times.
- A fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care.
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies.
- Diagnostic radiology facilities.
- A pathology laboratory.
- An organized medical staff of licensed doctors.

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral health care purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health

under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral health care services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside New York State must be approved by the Joint Commission on the Accreditation of Health Care Organizations.

For certain specified benefits, the definition of a "hospital" or "facility" may include a hospital, hospital department or facility that has a special agreement with Empire.

Empire's PPO does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted previously); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

In-Network Benefits

Benefits for covered services delivered by in-network providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is in Empire's PPO network,
- Is in the PPO network of another Blue Cross and/or Blue Shield plan, and

- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network.

Itemized Bill

A bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider's name and address and descriptions of each service, while a hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Empire identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.

Lifetime Maximum

The maximum amount of benefits your PPO will pay for covered expenses over the course of your lifetime.

Medically Necessary

Services, supplies or equipment provided by a hospital or other provider of health services that are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury,
- In accordance with standards of good medical practice,
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial, and
- The most appropriate level of service that can be safely provided to the patient.

The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's PPO contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Operating Area

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Out-of-Network Benefits

Reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs.

Out-of-Network Providers/Suppliers

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is not in Empire's PPO network,
- Is not in the PPO network of another Blue Cross and/or Blue Shield plan, or

- Does not have a negotiated rate with another Blue Cross and/or Blue Shield plan.

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that:

- Is in Empire's PPO network,
- Is in the PPO network of another Blue Cross and/or Blue Shield plan, or
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network.

Plan Administrator

The person who has certain authority concerning the Plan, such as Plan management, including deciding questions of eligibility for participation, and/or the administration of Plan assets. Empire is not the Plan Administrator. The Board of Trustees is the Plan Administrator.

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management Program to be fully covered by your Plan, such as planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.

Provider

A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional health

care practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license.

For behavioral health care purposes, "provider" includes care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

Treatment Maximums

Maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined. For example, if the Plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits in-network and 13 visits out-of-network.

HealthLine Audiotape Topics

Following is a list of some of our most popular health-related audiotape topics that you can listen to free of charge, 24 hours a day, seven days a week, when you call Empire HealthLine at 1-877-TALK-2RN (825-5276). See the "Health Management" section for more information on Empire HealthLine and instructions on how to listen to the tapes. These are our most requested audiotapes; there are

more than 1,100 available. If you do not see the topic that interests you, just ask one of the HealthLine nurses.

Aging
7805 Alzheimer's Disease
7845 Impotence in Older Men
7878 Sleep Problems

Alcohol Problems
4131 Alcoholism—Causes
4133 Alcoholism—The Disease of Denial

Arthritis
4172 Arthritis Or Rheumatism?
4171 Arthritis Symptoms
4175 Osteoarthritis

Back and Neck
4192 Back Pain—Causes
4193 Exercises for the Desk Bound
4199 Neck Pain

Blood and Circulatory
4211 Anemia
6104 Aneurysms

Bones, Joints and Muscles
4239 Gout

Cancer
6417 Colon Cancer
6429 Leukemia—Chronic
6481 Pancreatic Cancer
6453 Seven Warning Signs of Cancer
6459 Stomach Cancer
6465 Throat Cancer
6486 Thyroid Cancer

Cardiovascular Health
6101 Abnormal Heartbeat
6113 Chest Pain (Other Than Angina)
6116 Cholesterol—"Good" and "Bad"
6119 Congestive Heart Failure
6129 Early Warning of Heart Attack
6144 High Blood Pressure And Heart Disease
6170 Triglycerides

Common Illnesses
4332 Eczema

Digestive System
5400 Anal Fissure and Fistulas
4411 Colitis
4412 Constipation in the Digestive System
5402 Crohn's Disease
4413 Diarrhea in the Digestive System
4422 Diverticulosis and Diverticulitis
5404 Gallbladder Disease
5406 Gastroenteritis
4415 Heartburn and the Digestive System
4416 Hemorrhoids
5411 Intestinal Gas
4419 Irritable Bowel Syndrome
5414 Pancreatitis
5416 Rectal Bleeding
4421 Ulcers—Overview

Ear, Nose and Throat
4453 Ear Wax (Cerumen)
4456 Ringing in the Ear—Causes
4457 Sinus Problems

Eyes and Vision
4512 Double Vision
4513 Eye Symptoms Demanding Immediate Attention
4517 Spots and Floaters

Hormonal Disorders
4701 Hyperthyroidism (Overactive Thyroid)
4702 Hypothyroidism (Underactive Thyroid)

Infectious Diseases
4735 Fifth Disease
4724 Lyme Disease

Men's Health
4764 Prostate Problems

Mental and Emotional Health
6707 Anxiety
6717 Depression and its Symptoms
6720 Exhibitionism
6725 Grief and Loss
6733 Kleptomania
6735 Letting Go of Resentment
6737 Manic or Bipolar Depression
6744 Narcissism
6745 Nervous Breakdown
6748 Obsession and Compulsion
6749 Panic Attacks
6763 Schizophrenia
6773 Suicide
6777 Voyeurism

Respiratory Problems
4933 Chronic Cough—A Significant Respiratory Problem
4934 Emphysema

Sexually Transmitted Diseases
4951 Chlamydia
4953 Herpes
4955 Syphilis

Skin Health
4975 Psoriasis

Sports Medicine
7462 Tendonitis

Stress and How to Cope
5131 10 Stress Busters You Can Do
5132 Burnout—Is It Happening to You?
5133 Facing Financial Troubles
5135 Mental Exercises For Stress Management
5138 Stress—What Is It?

Symptoms
6127 Dizziness as a Symptom

Teenage Concerns
5227 Homosexuality
5228 Masturbation
5226 Think You're Gay?

Tests and Examinations
6418 Colonoscopy
6131 Echocardiography
5241 Endoscopic Retrograde Cholangiopancreato-grahy (ERCP)
7465 Thyroid Tests

Urinary and Genital Systems
5261 Bladder Stones
5262 Blood in Urine
5267 Women and Urinary Infections

Weight Control
6911 Choosing a Commercial Diet Program
6981 Teaching Your Body to Burn More Calories

Women's Health
7134 Hot Flashes
7135 Hysterectomy
7144 Menopause Problems?
5313 Sexual Response in Women
7191 Yeast Infections

Other Categories:
Allergies
Brain and Nervous System
Child Health and Development
Cosmetic and Reconstructive Surgery
Dental Health
Diabetes
Drug Abuse
Eating Disorders
Exercise and Fitness
Family Planning
Foot Care
General Health
Genetic Disorders and Birth Defects
Headaches
Health Quizzes
Hearing
HIV Infection/AIDS
Medications
Neurology
Newborn Care
Parenting and Family Life
Personal Safety
Pregnancy and Childbirth
Preparing for Emergencies
Surgery

Prescription Drug Benefit

The prescription drug benefit is administered by the UllicareRx/Medco Health Pharmacy Card Program ("Medco").

How it Works

You can get prescription drugs two ways: (1) from a participating Medco pharmacy, or (2) in the case of maintenance medications, by mail, through the Medco Health Home Delivery Pharmacy.

You and the Fund share the cost of these medications through "coinsurance" under which your copayment is a percentage of the cost of each prescription.

At a participating pharmacy. When you go to a participating pharmacy, you need to present your Medco identification card, and your doctor's written prescription. You'll receive up to a 30-day supply of your medication, for a copayment of:

- 15% of the Fund's cost of a generic drug,
- 15% of the Fund's cost for a brand-name drug.

There is a minimum copay of $5.

Keep in mind that there is no coverage if your prescription is filled at a non-participating pharmacy. You must pay the full cost of the prescription yourself.

Through the Medco Health Home Delivery Pharmacy. If your doctor prescribes a "maintenance medication," that is, a drug you'll be taking on a regular basis over a period of time, such as high blood pressure medication, you'll save money by using the Home Delivery Pharmacy. In this

case your copay will be only *10%* (rather than 15%) of the Fund's cost of the medication (either brand or generic) and you'll receive up to a *90-day* supply. Again, the minimum copay is $5.

Ordering through the Home Delivery Pharmacy. To order through the Home Delivery Pharmacy, here is what you need to do:

- To order your first prescription, you can get the required form from the Fund Office or by contacting Merck Medco at 1-800-473-3455, or online at *www.merckmedco.com*.
- Refills can be ordered over the phone or online.

Example. Assume your doctor prescribes a blood pressure medication that you will be taking on a regular basis.

- At a Medco pharmacy the brand-name version of this drug costs $53 for a 30-day supply, while the generic version of the same drug costs $14 for a 30-day supply.
- Through the Home Delivery Pharmacy Service the cost is $127 for a 90-day supply of the brand name and $14 for a 90-day supply of the generic.

The following chart shows the copay for the brand and generic versions of the drug, depending on whether the prescription is filled at a Medco pharmacy or through the Home Delivery Pharmacy Service.

COST COMPARISON FOR BLOOD PRESSURE MEDICATION

	Cost	Your Copay	Maximum Supply
Pharmacy			
• Brand	$ 53.00	$ 7.95	30 days
• Generic	$ 14.00	$ 5.00	30 days
Home Delivery			
• Brand	$127.00	$12.70	90 days
• Generic	$ 14.00	$ 5.00	90 days

Covered Drugs and Supplies

The following are covered under the Plan unless listed under the "Exclusions" section.

- Federal legend drugs,
- State restricted drugs,
- Compounded medications of which at least one ingredient is a legend drug,
- Insulin,
- Needles and syringes,
- Over-the-counter diabetic supplies,
- Legend contraceptive medications and devices,
- Drugs to treat impotency (all dosage forms except Yohimbine) for males only, age 18 and over, up to 4 tablets per month, and
- Self-administered injectable drugs on Ullicare/Medco's list of included self-administered injectables. For complete details on these, contact Medco. However, the types of injectables covered include certain vitamins, blood modifiers, hormones, growth hormones, immunomodulation drugs, diabetes

therapy, fertility agents, and other miscellaneous self-administered injectables.

Exclusions

The following are excluded from coverage under the Plan:

- Non-federal legend drugs,
- Over-the-counter contraceptive jellies, creams, foams and devices,
- Injectable medications that are not on Ullicare/Medco's list of covered injectables,
- Smoking deterrents,
- Homeopathic medications,
- Mifeprex,
- Therapeutic devices or appliances (for example, a diabetes monitor),
- Drugs whose sole purpose is to promote or stimulate hair growth (for example, "Rogaine" and "Propecia") or which are used for cosmetic purposes only (for example, "Renova," "Vaniqa," "Tri-Luma," "Botox-Cosmetic," "Solage," "Avage," "Epiquin"),
- Allergy serums,
- Biologicals, immunization agents or vaccines,
- Blood or blood plasma products,
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual,
- Medication for which the cost is recoverable under any Workers' Compensation or other occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member,

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals,
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order,
- Charges for the administration or injection of any drug, and
- Prescriptions filled in excess of the monthly dispensing limit for a medication (for example, erectile dysfunction drugs such as Viagra are limited to four (4) per month and 48 per year).

Questions?
• If you have any questions about your prescription drug benefits, call Medco at 1-800-818-6602. You can also access their website at www.medcohealth.com.

Optical Benefit

You and each covered dependent are entitled to receive an eye exam and lenses once every 12 months and frames once every 24 months.

How it Works

The Plan covers a wide range of vision-related services and products. While you can go to any optical provider, you generally pay less when you use a provider in the National Vision Administrators (NVA) network.

How To Locate an NVA Provider
• To locate an NVA provider near you, call NVA at 1-800-672-7723 or visit the NVA website at: www.e-nva.com.

In-Network Benefits

To use an NVA in-network provider, call the provider to schedule an appointment and identify yourself as a participant in the Fund. The provider will contact NVA to verify your eligibility.

At the time of your first appointment you must provide your NVA identification card. After the services have been provided, the provider will have you sign a claim form and he or she will send it to NVA for processing and payment. You do not pay anything unless you select a service, frame or treatment that is not covered in full under our arrangement with NVA.

Here's what you are entitled to when you use an NVA provider:

Eye exam. A complete analysis of the eyes and related structures once every 12 months.

Lenses. Clear impact-resistant lenses to correct vision acuity once every 12 months.

Frames. Frames are covered once every 24 months. If you choose a frame that costs more than what is allowed by the Plan or a frame that requires oversized lenses, then you must pay the difference between the scheduled amount reimbursed by the Plan and the total cost.

Contact lenses. A contact lens benefit (up to $200 for examination and lenses) when contact lenses are considered "medically necessary" for any of the following reasons:

- To correct extreme visual acuity problems that cannot be corrected with eyeglasses,
- Following cataract surgery,
- Anisometropia (unequal refractive power in two eyes), or
- Keratoconus (protrusion of the cornea).

In each of the four cases described above, NVA must authorize the contact lens expense in advance.

If you want lenses for any reason other than one of those listed previously ("cosmetic" contact lenses), the Fund will cover $100 of the cost, including the examination.

If You Go to an Out-of-Network Vision Provider

If you go to a provider who is not part of the NVA network, you have to pay the full cost of the services you receive and items you purchase, and must then submit a claim for reimbursement. Here is how eligible out-of-network expenses are reimbursed.

SCHEDULE OF OUT-OF-NETWORK VISION BENEFITS

Eligible Expense	Reimbursement
Vision Analysis, including Tonometry	$
Tonometry (Glaucoma Test)	$
Single vision lenses	$ 15 per pair
Bifocal lenses	$ 21 per pair
Trifocal lenses	$ 30 per pair
Aphakin lenses	$ 60 per pair
Frames	$
Cosmetic contact lenses (in lieu of all other benefits, including vision analysis)	$
Medically required contact lenses, including exam (prior approval recommended)	$

For reimbursement, submit a copy of the itemized receipt, along with a note containing the patient's name, participant's name, Social Security number (or the patient's name along with a photocopy of your identification card). All claims for reimbursement must be submitted within **12 months** of the date of service or they will be denied as untimely.

The claim for reimbursement, along with the required supporting documentation, should be submitted to NVA at this address:

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Limitations and Exclusions

The Optical Benefit does *not* cover the following expenses, even when they are incurred in-network.

- A frame costing more than the Plan allowance,
- Oversized lenses,
- Photochromic lenses (gray and brown),
- Blended, seamless lenses,
- Lenses tinted, gradient or fashion colors,
- Polished edges,
- Coated lenses—ultra-violet, anti-reflective or edgecote mirror, Super A.R., color,
- Smart segment,
- Scratch resistant (66 or manufacturer applied),
- Rimless,
- Polycarbonate,
- Progressive lenses.

Questions?
• If you have any questions about your vision benefits, contact NVA at 1-800-672-7723 or call the Fund at 1-914-375-0591.

Dental Benefit

The Fund pays dental benefits according to the Schedule of Dental Benefits at the end of this section. These benefits are available to you and your covered dependents. The dental program is administered by S.I.D.S.

Maximum benefits. The maximum the Fund pays for any procedure is the amount shown on the Schedule of Dental Benefits. The Fund has a lifetime maximum of $2,700 per covered person for *orthodontic* services.

How it Works

In order to qualify for reimbursement, an expense must meet all of the following requirements:

- It must be listed on the Schedule of Dental Benefits.
- It must be performed by or under the direction of a licensed dentist.
- It must both begin and be completed while the patient is covered by the Plan, unless there is an "extension of benefits," as described later in this section.

Filing a Claim for Benefits

After your dental work is completed, your dentist should complete all items in the "Dentist Information" portion of the S.I.D.S. claim form (available from the Fund Office). Your dentist should list the procedures, dates of services and charges and sign the form where indicated. You should then complete all items in the "Member Information" portion of the form. Don't forget to include spouse and dependent information.

The completed claim form, along with x-rays and other attachments, should be sent to:

Self-Insured Dental Services, Dept. 49
P.O. Box 9005
Lynbrook, NY 11563-9005

If you want to have payment made directly to your dentist, instead of to you, then you should also sign the "Authorization to Assign Benefits" box on the claim form. If you don't do this, then reimbursement will be made to you.

Dental claims must be filed within **90 days** after the date of service. Claims filed more than 90 days from the date of service will not be reimbursed.

Extension of benefits. Generally, the Plan covers only services provided while coverage is in effect. However, an extension of benefits is available for treatment that starts while coverage is in effect but that isn't completed until after your coverage ends. These exceptions include:

- Crowns, inlays, fixed bridgework and full or partial dentures if a pretreatment authorization was issued and impressions were taken and/or teeth were prepared while coverage was in effect and the device was installed or delivered within one month after your eligibility ended, and
- Root canal therapy, where the pulp chamber of the tooth was opened while coverage was in effect and the treatment ended within one month after eligibility ended.

No extension of benefits is available for services other than those shown above.

Pretreatment Review Estimates

This optional feature gives you and your dentist advance notice of what benefits will be provided by the Plan before your treatment begins. Pretreatment review estimates are

not mandatory and claims for benefits will not be denied if a pretreatment review estimate has not been filed.

You should have your dentist file a "Claim Form for Pretreatment Review" if the course of treatment is expected to cost more than $300 in a 90-day period and/or includes any of the following services: inlays, crowns, bridges, dentures, laminate veneers or periodontal surgery.

Once the dentist completes his or her part of the form, you should complete your part of the form and mail it together with required supporting documentation, such as x-rays, to:

Self-Insured Dental Services, Dept. 49
P.O. Box 9005
Lynbrook, New York 11563-9005

After S.I.D.S. reviews the form, both you and your dentist will receive a report stating the Plan allowances for each procedure. If there are disallowances, the report will also indicate the reasons for these.

If you receive a pretreatment estimate for a proposed course of treatment that was submitted by one dentist, the statement will remain valid for one year after issuance, even if you elect to have some or all of the work done by another dentist.

Don't forget to submit a pretreatment review request if you want to know what will be covered under the Plan prior to beginning treatment. It may save you money.

Note. A pretreatment review estimate is not a guarantee of payment. The work must be done while the patient is still covered by the Plan, unless there is an "extension of benefits," as explained earlier.

Alternate Procedures

In some cases, there is more than one way to treat a dental problem. When you submit a request for pretreatment review, the Plan will consider alternate procedures and may authorize an amount of reimbursement based on an alternate procedure (which may differ from the one proposed by your dentist) that will provide a professionally acceptable result in a cost-effective manner. In such a case, if you choose to go ahead with the original treatment plan, reimbursement will be based on the alternate course of treatment, and you will be responsible for paying any difference.

Exclusions

Expenses not covered under the Plan include expenses incurred as a result of:

- Cosmetic restoration,
- Replacement of a lost or stolen appliance,
- Replacement of a bridge, crown or denture within five years after it was originally installed; replacement of a bridge, crown or denture that is or can be made usable according to common dental standards,
- Orthodontic services,
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) reposition teeth by orthodontic means,
- Multiple bridge abutments,
- A bridge or denture that replaces a tooth that was missing when the individual became covered by the Plan,

- A surgical implant of any type, including any prosthetic device attached to it,
- Services that do not meet common dental standards,
- Services not included in the Schedule of Dental Benefits, and
- Services for which benefits are not payable according to the "General Limitations" section, below.

General limitations. Benefits will not be paid for:

- Work-related injury,
- Sickness covered under workers' compensation or similar law,
- Treatment in a hospital owned or run by the U.S. government, unless there is a legal obligation to pay charges for that treatment whether or not there is insurance,
- Treatment payment which is unlawful where the patient resides when the expenses are incurred,
- Care for which charges would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family
- Unnecessary care, treatment or surgery,
- Charges that exceed "reasonable and customary charges," as determined by S.I.D.S,
- Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society, and
- Treatment for which payment is available through a public program.

Questions?
• Contact S.I.D.S. at: 1-800-537-1238 or 1-516-396-5500 or online at www.asonet.com

SCHEDULE OF DENTAL BENEFITS

Diagnostic and Preventive	
Oral examination maximum—two per calendar year	$ 22.00
Full mouth series x-rays—10 to 14 periapical and bitewing films	55.00
Intraoral film—periapical or bitewing per film	6.00
Occlusal film	15.00
Cephalometric film	35.00
Extraoral film	25.00
Panoramic film	40.00
X-ray maximum of $55 per calendar year	
Prophylaxis	40.00
Prophylaxis—child	35.00
Prophylaxis maximum—2 per calendar year	
Palliative treatment—no other treatment that visit	14.00
Fluoride treatment—excluding prophylaxis—to age 19, maximum two applications per year	10.00
Sealant—per tooth: permanent posterior teeth to age 15 and maximum one application per lifetime	15.00
Space maintainer	100.00
Recement space maintainer	30.00

Restorative	
Silver Amalgam Fillings • One surface	$ 45.00
• Two surfaces	55.00
• Three surfaces	65.00
• Four or more surfaces	70.00
Composite Resin • One surface	55.00
• Two surfaces	65.00
• Three surfaces	75.00
• Four or more and incisal angle	75.00
Gold Inlay	210.00
Porcelain Inlay	51.00
Recement Crown or Inlay	35.00
Crowns • Porcelain jacket	325.00
• Plastic with metal	340.00
• Porcelain with metal	400.00
• Full cast or gold 3/4 cast	325.00
Prefab Stainless Steel Crown—Primary Tooth	50.00
Post and Core, Pre-Fabricated	100.00
Cast Post and Core	125.00
Pin Support per Tooth	15.00

Endodontics (x-ray evidence of satisfactory completion required)	
Pulp-Cap, Direct	$ 15.00
Vital Pulpotomy	50.00
Root Therapy • One canal	325.00
• Two canals	375.00
• Three or more canals	425.00
Apicoectomy • First root	150.00
• Maximum per tooth	300.00
Retrograde Filling	85.00
Hemisection	100.00

Prosthodontics	
Complete Denture—immediate or permanent	$575.00
Partial Denture—unilateral	255.00
Partial Denture—bilateral	
• Acrylic base	375.00
• Acrylic base with clasps and rests	500.00
• Cast metal base	575.00
Denture Reline	
• Office procedure—complete or partial	75.00
• Laboratory procedure—complete or partial	100.00
• Tissue conditioning	40.00
Bridge Abutment	
• Crown—plastic with metal	340.00
• Crown—porcelain fused to metal	400.00
• Crown—full cast	325.00
• Crown—3/4 cast	325.00
Bridge Pontic	
• Full cast	325.00
• Plastic with metal	340.00
• Porcelain with metal	400.00
Recement Bridge	50.00
Semi-Precision Attachment	190.00
Denture Repairs	
• Adjust complete denture	30.00
• Broken denture base	90.00
• Replace tooth in denture	60.00
• Replace broken facing	25.00
• Replace broken clasp	75.00
• Reattach clasp	75.00
• Add tooth to existing partial denture	60.00
• Add clasp to existing partial	80.00

Periodontics	
Root Scaling and Gingival Curettage—including prophylaxis, per visit—maximum payment of $240 per calendar year	$ 60.00
Periodontal Surgery—confirmation by charting and/or x-rays required—lifetime maximum of $1,400 per covered individual Per quadrant of at least 5 teeth: • gingivectomy, gingivoplasty, muco-buccal and graft—per quadrant	110.00
• osseous surgery including gingivectomy per quadrant	400.00
Periodontal Maintenance	60.00
Oral Surgery	
Simple Extraction	$ 50.00
Surgical Extraction—must be demonstrated by x-ray • Erupted tooth	100.00
• Retained root	115.00
• Impaction—soft tissue	125.00
• Impaction—partial bony	200.00
• Impaction—complete bony	275.00
Alveoloplasty—per jaw	60.00
Biopsy Soft Tissue	75.00
Cyst Removal < 1.25 CM	75.00
Cyst Removal > 1.25 CM	125.00
Incision and Drainage	50.00
General Anesthesia, 1ST half hour	125.00
General Anesthesia, additional 15 minutes	25.00

Orthodontics (lifetime maximum of $2,700 per covered individual)	
Diagnosis and Initial Orthodontic Appliances—fixed appliance	$400.00
Active Treatment—per month of treatment—maximum 20 months of treatment	100.00
Passive Treatment—per 6 months of treatment—maximum 18 months of treatment	50.00

Weekly Disability Benefit

This benefit, which is insured by Amalgamated Life Insurance Company, provides a weekly income in the event a disabling accident or injury that occurs **off the job** prevents you from working at your regular or customary occupation, and for which you are under the care of a physician. This benefit is only available to active employees. You do not have to be confined to your home to receive benefits.

What the Benefit Is

The benefit is $240 per week.

When Payments Start and End

Benefits begin as of the eighth (8th) day of a disability due to an accident or illness, in accordance with New York State Disability Benefits law.

Payments continue for as long as you remain disabled, up to 26 weeks. (If the disability lasts more than four weeks, a supplemental medical report of disability will be required by Amalgamated Life with every fourth week of disability.)

Successive periods of disability. Generally, successive periods of disability are subject to one combined 26-week limit unless the second (or subsequent) period of disability:

- Begins after you have returned to active full-time work for at least two consecutive weeks, or
- Results from causes entirely unrelated to the causes of the previous disability and you returned to work for at least one full day between the two disabilities.

Filing a Claim for Benefits

Your disability should be reported to the Fund Office, preferably within 20 days after it starts. The Fund Office will then send you the claim form. The claim form should be returned promptly, as a delayed filing may cause a reduction in benefits. (Under New York law all benefits are subject to forfeiture if proof of disability is not filed within 26 weeks of the beginning of disability.)

Exclusions

Benefits cannot be provided for a period of disability:

- Involving workers' compensation cases (that is, job-related disabilities),
- During which you are not under the direct care of a physician. A period of disability will not be considered as having started earlier than three days before the date you first see a physician,
- Caused while you were committing a felony, a criminal act or misconduct,
- Due to an intentionally self-inflicted injury of any kind, while sane or insane, or
- Due to war or any act of war, declared or undeclared.

Questions?
• If you have any questions about weekly sickness and accident benefits, call the Fund Office at 1-914-375-0591 or 1-800-765-0338.

Life Insurance and Accidental Death and Dismemberment Benefits

Life Insurance (Death Benefit)

The benefit described in this section covers active employees only. A reduced life insurance benefit covers eligible retirees and is described in the section called "Retiree Benefits." There is no life insurance benefit for dependents. This benefit is insured by Amalgamated Life Insurance Company.

What the benefit is. If you die while coverage is in effect, your designated beneficiary will receive a lump sum payment of $15,000.

Coverage generally ends when your Fund coverage ends. However, if you are entitled to an extension of coverage during a period of qualifying disability, as described earlier, your $15,000 life insurance coverage continues for up to one year.

In the event your disability continues, and you retire on a disability pension following the one year extension of coverage, you will continue to be covered by a $5,000 life insurance benefit.

Once you retire, you will have a $5,000 life insurance benefit.

Your beneficiary. When your coverage starts, you'll be given an enrollment form on which you designate the person or persons to receive this benefit if you die. You may change your beneficiary or beneficiaries at any time by filing a new beneficiary designation with the Fund

Office, but any such change is not effective unless the Fund Office receives the notice prior to your death.

If you do not name a beneficiary, or if one or all of your beneficiaries die before you, then the benefit will be paid to the executors or administrators of your estate or, at the option of the insurance company, to the surviving individual(s) in the first of the following groups that has at least one surviving member:

- Your surviving spouse,
- Your children (in equal shares),
- Your parents (in equal shares), or
- Your sisters and brothers (in equal shares).

Living benefit. While life insurance can generally be paid only to your beneficiary upon your death, our program has a "living benefit rider" under which 50% of the amount that would be paid to your beneficiary upon your death may instead be paid to you if you are terminally ill.

For this purpose, "terminally ill" means you have a condition caused by sickness or accident that a licensed physician has determined will directly result in a life expectancy of no more than 12 months. The insurance company must approve this determination.

Any living benefit paid to you may be considered taxable income under federal and/or local tax laws, so you should consult a tax advisor before receiving this benefit. In addition, your eligibility for public assistance programs could be affected if you receive this benefit.

You are not eligible for the living benefit if premiums on the group life insurance have not been paid; if all or part of your life insurance benefits are paid as part of a divorce settlement; if your terminal illness results from attempted suicide or any self-inflicted injury; or if you made an

absolute assignment or an irrevocable beneficiary designation of your life insurance.

If you do elect the living benefit, **then the benefit paid to your beneficiary or beneficiaries upon your death will be reduced by the amount paid to you, plus an administrative fee.**

Accidental Death and Dismemberment Benefit (AD&D)

This benefit covers active employees only and is paid if you die or are severely injured in an accident. This benefit is insured by Amalgamated Life Insurance Company.

The maximum benefit payable under this benefit is $15,000 and is in addition to the death benefit described in the preceding section. This full benefit is payable to your beneficiary if you die as a result of an accident; full or partial benefits are payable to you if you are severely injured in an accident. In either case, the loss must be suffered within ninety (90) days from the day of the accident.

SCHEDULE OF COVERED LOSSES

Coverage Amount Payable	For Accidental Loss Of:
$15,000	Life, or any combination of two hands, feet or sight in both eyes
$ 7,500	One hand or one foot; Sight of one eye

If you continue working past age 65. Your AD&D coverage remains in effect up until age 70, assuming you're still working. There is no AD&D coverage once you reach age 70, even if you continue to work.

The AD&D benefit covers active employees only and cannot be paid for losses resulting from:

- War or any act of war,
- Bodily or mental infirmity,
- Disease or illness of any kind,
- Medical or surgical treatment (except medical or surgical treatment required solely because of injury),
- Bacterial infection (except pyogenic infections resulting solely from injury),
- Intentionally self-inflicted injury,
- Suicide or any attempt at suicide,
- Alcohol or substance abuse,
- Injury sustained while engaged in aeronautics and/or aviation of any kind except while a fare-paying passenger in an aircraft licensed to carry passengers,
- Commission of or participation in a crime.

Filing a Claim for Benefits

The Fund Office has information on the forms that must be filed and supporting documentation that must be provided to claim death and dismemberment benefits.

Questions?
• If you have any questions about the life insurance and AD&D benefits, you should contact the Fund Office at 1-914-375-0591 or 1-800-765-0338.

Retiree Benefits

While Plan coverage generally stops once you no longer meet the active eligibility requirements, as described in the "Eligibility and Participation" section, if you meet the requirements for retiree coverage described in "Eligibility and Participation," you will be entitled to the special retiree benefits described in this section.

What the Benefits Are

Subject to the limitations described in the section called "Eligibility and Participation," retiree benefits include:

- From ages 55 to 65, you have the same medical benefits as active employees, and a $5,000 life insurance benefit, provided your last employer prior to retirement is still contributing to the Fund. However, you do not have dental, optical or prescription drug coverage, or AD&D or weekly disability coverage.
- Once you reach age 65, you are entitled to the Fund's "Medicare Supplemental" benefit, which reimburses you for the amount you must pay under Medicare for the first day of hospital coverage unless you have personal "Medigap" coverage for this expense. If your covered spouse reaches age 65 before you do, his or her coverage will change to the "Medicare Supplemental" benefit. You also continue to have $5,000 in life insurance coverage, provided your last employer is still making contributions to the Fund.

Enrollment. To receive these benefits, you'll need to provide the Fund Office with verification of retiree status and a copy of your Medicare card.

Filing a Claim for Benefits

Until you reach age 65, you claim benefits the same way you did when you were an active employee.

Once you reach age 65, you may claim reimbursement for the Medicare amount you pay for the first day of hospitalization by submitting a copy of your hospital bill to the Fund Office.

Medicare Benefits

Medicare has traditionally consisted of two parts: Part A, which provides hospital benefits, and Part B, which provides medical benefits. Part A is provided at no cost to you, while there is a monthly premium for Part B.

It's a good idea to contact the Social Security Administration at least three months before you reach age 65 to sign up for both Medicare and Social Security retirement benefits.

If you have any questions about retiree coverage, you should contact the Fund Office at 1-914-375-0591 or 1-800-765-0338. If you have questions about Medicare, you should contact the Social Security Administration. In addition, you can get information on Medicare at the Medicare website: *www.medicare.gov*.

Teamster Center Services

The Fund also offers the services of the Teamster Center Services (TCS), which is administered from Montefiore Hospital and is available to all covered individuals who have medical coverage.

TCS provides advice and referrals for mental health care, and alcoholism and drug abuse.

TCS has rate arrangements with many substance abuse and mental health treatment facilities, under which your out-of-pocket expenses may be substantially limited or eliminated altogether. In addition, if you are admitted to a non-TCS facility, once you contact TCS as soon as possible after the admission, TCS may be able to arrange a transfer to, or may refer you to, a facility that has such an arrangement with TCS. Therefore, it is in your interest to contact TCS before any treatment to understand the amounts payable and to obtain the maximum benefits possible with the least out-of-pocket expense. If you receive any mental health or substance abuse services, any claim forms or other required information should be submitted to Empire as described in the Empire section of this SPD.

How to Obtain Benefits

To get help from TCS, all you or your covered dependent have to do is call TCS at 1-718-920-5115 or 1-800-433-4827. If TCS can't provide the help you need over the phone, then an appointment will be made for you to visit the Center. TCS is open Monday through Friday, from 8:30am to 4:30pm. TCS help is confidential.

Coordination of Benefits

In situations where both spouses work, family members may be covered under more than one health plan, and there's a possibility the total benefits paid under both plans could exceed the medical expense actually incurred.

To avoid duplicate payment of benefits, our Plan has a "coordination of benefits" (COB) provision. This provision ensures that if you or a covered dependent is covered by another plan, benefits from all plans combined will not exceed 100% of the "Allowable Expense" for the care.

"Allowable Expense" means any necessary, reasonable and customary item of expense that is covered under at least one of the plans covering the individual for whom a claim is made.

The benefits provided under this Plan will be coordinated with the benefits of any other plan providing benefits for Allowable Expenses, including the New York State no-fault automobile insurance law.

Which Plan Pays First

First, if you're covered by two plans and the other plan does not have a coordination of benefits provision, the other plan will always pay its benefits first, before this Plan pays any benefits.

Second, if **both** plans have COB provisions, benefits will be paid in the following order:

Employee/dependent rule. The plan covering an individual as an employee is primary (i.e., pays first) and

the plan covering an individual as a dependent is always secondary (i.e., pays second).

Birthday rule. For dependent children of parents who are not separated or divorced, the plan of a parent whose birth date (month and day, not year) falls earlier in the calendar year is primary and the plan of the parent whose birthday falls later is secondary. In the event both parents have the same birthday, the plan that covered a parent longer will be primary (unless the other plan does not have this rule, but does have a rule based on gender, in which case the father's plan will be primary).

Children of separated/divorced parents rule. For dependent children of parents who are separated or divorced, if a court decree (such as a Qualified Medical Child Support Order, or "QMCSO") designates one parent as responsible for medical expenses, then benefits will be paid according to that decree, provided the plan has notice of that decree. Where there is no such order, then the plan of the parent with custody is the primary plan. If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the plan of the stepparent will be secondary and the plan of the parent without custody is tertiary (i.e., pays third).

Active/inactive rule. The plan covering an individual who is an active employee is primary and the plan covering an individual as an inactive employee (such as a retired or laid-off employee) is secondary.

Longer/shorter rule. If none of the above rules apply, the plan that has covered the individual longer is the primary plan and the plan that has covered the individual for less time is secondary.

If this Plan is the Secondary Plan. If this Plan is secondary, then benefits will be reduced so that total benefits will not be greater than the allowable expenses.

Also this Plan will not pay more than the amount the Plan would normally pay if it were primary.

Tips for Coordinating Benefits. To receive all benefits available to you, file your claim under each plan. File claims first with the primary plan, and later with the secondary plan. Be sure to include the Explanation of Benefits from the primary plan when you submit your claim to the secondary plan.

If You Receive An Overpayment of Benefits. If you receive benefits that either should not have been paid or exceed the amount that should have been paid, you must return the overpayment. Overpayments include, but are not limited to, payments for services that are not covered by the Plan, payments on behalf of individuals who are not covered by the Plan, duplicate payments for services, or payments that exceed the amount due under the Plan.

Claim Review and Appeal Procedures

Definitions

A claim for benefits is a request for benefits made in accordance with the Plan's claims procedures. A simple inquiry about Plan provisions or eligibility will not be treated as a claim, nor will a request for prior approval of a benefit that does not require prior approval be treated as a claim.

Please keep the following definitions in mind in reviewing these procedures:

A **pre-service claim** is a claim for a benefit that requires you to obtain approval of the benefit in advance of obtaining the care. For example, hospital admissions require pre-approval (also called precertification).

A **post-service claim** is a claim for a benefit that does not require pre-approval or precertification before you receive the benefit. For example, most doctor visits do not require you to obtain precertification before you receive the service.

An **urgent claim** is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service determinations (1) could seriously jeopardize your life or health or your ability to regain maximum function, (2) in the opinion of a physician with knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is urgent will be determined applying the judgment of a prudent layperson who possesses an average

knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is urgent shall be treated as an urgent care claim.

A concurrent care claim is a claim that is reconsidered after an initial approval is made, but subsequently reduced, terminated or extended. An example would be an inpatient mental health admission that is originally precertified for 10 days but is then reviewed at five (5) days to determine if the full ten-day confinement is appropriate. In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

Major Medical and Hospitalization Benefits Claim Procedures

Please refer to the Empire section of this SPD.

Dental Benefit Claim Procedures

Please refer to the Dental section of this SPD.

Optical Benefit Claim Procedures

Please refer to the Prescription Drug section of this SPD.

Prescription Drug Benefit Claim Procedures

Please refer to the Prescription Drug section of this SPD.

Substance Abuse and Mental Health Benefits Claim Procedures

Please refer to the TCS section of this SPD.

Time Frames for Deciding Claims

For information about Empire's time within which it decides claims, see the Empire section of this SPD. For all other types of claims, the following time frames apply:

Post-Service Claims. Ordinarily, you will be notified of the decision on your claim within **30 days** from receipt of your claim. This period may be extended one time up to **15 days** if necessary due to matters beyond the control of the decision maker provided that, prior to the expiration of the initial 30-day period, you are notified of the reasons for the extension and the date by which a decision will be made. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have **45 days** from your receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period you are given to supply additional information, the 30-day period for deciding the claim will be suspended from the date of the extension notice until the earlier of (i) 45 days, or (ii) until the date you respond to the request. The decision maker then has **15 days** to decide your claim and notify you of the determination.

Pre-Service Claims. If you improperly file a pre-service claim, provided that the improperly filed claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested, you will be notified of the proper claims procedures as soon as possible but not later than **5 days** after receipt of your improperly filed claim. Notification may be oral; however, written notification will be provided upon request.

If you provide all the required information when you precertify, you will be notified of the decision on your precertification request within **15 days** of your claim unless

additional time is needed due to matters beyond the control of the Fund. Under those circumstances, the time to decide your claim may be extended up to **15 days**. Prior to the expiration of the initial 15-day period, you will be notified of the circumstances necessitating the extension and the date on which a decision will be made. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period which you are provided to supply additional information, the 15-day period for deciding the claim will be suspended from the date of the extension notice until the earlier of (i) either 45 days, or (ii) the date you respond to the request. Your claim will be decided and you will be notified of the determination within **15 days**.

Concurrent Care Claims. A reconsideration of a benefit with respect to a concurrent claim that involves the termination or reduction of a previously approved benefit (other than by plan amendment or termination) will be made within **24 hours** of receipt of your request for reconsideration or early enough to have an appeal decided before the benefit is reduced or terminated.

Urgent Care Claims. If you improperly file an urgent care claim, you will be notified as soon as possible, but not later than **24 hours** after the claim is received, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

The Fund will respond to you (and your doctor) with a determination of your urgent care claim by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receiving the claim. The determination will be confirmed in writing.

If an urgent care claim is received without sufficient information to determine whether and to what extent benefits are covered or payable, the Fund will notify you (and your doctor) as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within **48 hours**. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than **48 hours** after receipt of the specified information.

Notice of Decision

You will be provided with a written notice of a denial of a claim. This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits.
- A statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse benefit determination on review. **However, please note that you must first exhaust the appeals process before filing a lawsuit.**
- If an internal rule, guideline or protocol was relied on in deciding your claim, you will receive either a copy of the rule or a statement that it is available on request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar

exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Medical and Hospitalization Appeals Procedure

Please refer to the Empire section of this SPD for information about Empire's appeal procedures. In addition to the procedures described in that section, there is an optional appeal to the Board of Trustees, which is described below.

Dental Appeals Procedure

If your claim is denied in whole or in part, you may appeal to S.I.D.S. in writing within **180 days** after you receive the denial and stating why you believe the denial is incorrect. You should also include any documentation you have to support your claim. You will receive a notice of the decision within **60 days** after your appeal is received.

Vision and Prescription Appeals Procedure

If your claim is denied in whole or in part, you may appeal to the Board of Trustees (the "Trustees") in writing within **180 days** after you receive the denial and state why you believe the denial is incorrect and include any documentation you have to support your claim. Decisions on appeals are ordinarily made at the next regularly scheduled Trustees' meeting after your appeal is received. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting after your appeal is received. In special circumstances, a delay until the third regularly scheduled meeting after your appeal is received may be necessary. You will be advised in writing in advance if this extension will be necessary. You will be notified of the Trustees' decision as soon as

possible, but no later than five (5) days after the decision is reached

Optional Appeal to the Board of Trustees

If Empire denies your second level appeal in whole or in part (or denies your first level appeal in the case of urgent care claims or urgent concurrent claims) or if S.I.D.S. denies your appeal of the denial of your dental claim, you have the **option** of filing an appeal with the Board of Trustees (the "Trustees"). Your appeal must be in writing and must be made within **60 days** after you receive notice of denial of your appeal by Empire or S.I.D.S. and should state why you believe the decision is incorrect and include any documentation you have to support your claim. Ordinarily, decisions on optional appeals will be made at the next regularly scheduled meeting of the Trustees after your appeal is received. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting after your appeal is received. In special circumstances, a delay until the third regularly scheduled meeting after your appeal is received may be necessary. You will be advised in writing in advance if this extension will be necessary. You will be notified of the Trustees' decision as soon as possible, but no later than five (5) days after the decision is reached. You may call the Plan to find out the date of the next regularly scheduled Trustees' meeting.

This appeal to the Trustees of Empire's or S.I.D.S.' denial of your claim is voluntary. The Plan will not assert your decision not to file an appeal with the Trustees as a defense if you sue the Plan instead of appealing to the Trustees. If you do appeal to the Trustees, the Plan agrees that any statute of limitations or other defense base on timeliness will be suspended during the time that the appeal to the Trustees is pending. The decision whether to appeal to the

Trustees will have no effect on your rights to any other benefits under the Plan.

Appeal Rights

Right to Review Documents and to Obtain Other Information. You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision: it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with administrative processes for ensuring consistent decision making; or it constitutes a statement of policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical experts, if any, who advised the Plan or Empire concerning your claim, without regard to whether the advice was relied on in deciding your claim.

Right to Independent Review. A different person will consider your appeal than the one who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including any additional documents and comments you submit. Similarly, Empire will not afford deference to its first level appeal decision and the reviewing parties will not be the same parties who made the decision at the first level of review nor will they be subordinates of those parties. Nor will the Trustees afford deference to Empire's first or second level appeal decision(s) or TCS's or S.I.D.S.'decision and the reviewing parties will not be the same parties who made the decision at Empire or TCS or S.I.D.S., nor will they be the subordinates of those parties.

Cases Involving a Medical Judgment. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or

experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Notice of the Determination of Your Appeal. Appeal decisions will be in writing and will include the following information:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim upon request and free of charge.
- A statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review. **However, please be aware that you must first exhaust the appeals process before filing a lawsuit.**
- If an internal rule, guideline or protocol was relied upon, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar conclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Subrogation and Restitution Obligation

The Fund's subrogation and restitution policy seeks to conserve the assets of the Fund by imposing the expense for injuries suffered by Participants and/or their eligible dependents on the parties responsible for causing the injuries or illnesses. If you or your dependents receive benefits from the Fund for injuries caused by someone else (such as an automobile accident), the Fund, through subrogation, has the right to seek repayment from the other party or his insurance company. In the event you, your dependent, legal representative or agent, by suit, settlement or otherwise, recover any monies from any third party or insurer (regardless of how this recovery is classified in the settlement or judgment), the Fund has the right to be reimbursed by you, your dependent, legal representative or agent for the full amount of all claims paid by the Fund. All monies and/or assets received by you, your dependent, legal representative or agent as the result of such recovery are deemed held in trust on behalf of the Fund to cover all benefit payments by the Fund on your behalf. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Fund for benefits paid. The Fund has the right of first reimbursement out of any recovery you obtain, even if you are not fully compensated ("made whole") for your loss. If you choose not to pursue the liability of a third party, the Fund will be subrogated to your right of recovery and may pursue your claims against the third party.

If you or your dependent has an injury or illness caused by a third party, the Fund will pay benefits for that injury or illness subject to the conditions that you or your dependent:

- Do not take any action that would prejudice the Fund's ability to recover benefits,

- Will cooperate in doing what is reasonably necessary to assist the Fund in obtaining any recovery, and
- Sign the Subrogation Agreement as explained in more detail below.

You are required to notify the Fund Office as soon as possible of any third party claim you or your dependent may have for which the Fund has paid or may pay benefits. If you retain an attorney, he or she must notify the Fund within ten days of any demand made or suit filed against a third party. In addition, you are required to notify the Fund immediately of any recovery, whether in or out of court, which you or your dependent obtain. The Fund's right to reimbursement shall not be reduced by the payment of attorney's fees or costs associated with the action. The Fund's right of subrogation from any funds received by you, your dependent, legal representative or agent as a result of a judgment, settlement, or other action has first priority over all other claims, rights, etc.

The Fund and/or Empire will send you a Subrogation Agreement. No benefits will be paid for any claims of you or of your dependents until the Fund Office receives a signed Subrogation Agreement from you. However, the Fund's right of subrogation and restitution is not dependent upon the execution of such Agreement. If one of your minor dependents is injured as a result of the act or omission of a third party, the dependent's parent or legal guardian must sign the Subrogation Agreement. The Fund may also periodically require you to provide information as to any claims you assert against any other party as a result of the injury. If you refuse to reimburse the Fund or to cooperate with the Fund in obtaining reimbursement, the Fund has the right to recover any amounts paid and may offset such amounts against any future benefits payable to you or your dependents.

Fraud

Benefits can be discontinued, denied, suspended or reduced for Participants or their dependents that have been found to have engaged in fraud against the Fund. Fraud includes, but is not limited to, the making of a false claim for benefits and the furnishing of false information to the Fund Office. One example is if you fail to advise the Fund that you and your spouse became divorced, and your spouse continues to submit claims as if you were still married. Where a Participant is found to have engaged in fraud, the Fund may suspend or permanently discontinue coverage for the Participant and his/her dependents and the Fund will require repayment of benefits paid due to the fraud.

Summary of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO YOU, THE PARTICIPANT, AND YOUR ELIGIBLE DEPENDENTS.

Under federal privacy law, commonly known as the Health Insurance Portability and Accountability Act ("HIPAA"), the Fund is required to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI") held by the Fund. Below is a brief summary of the Fund's Notice of Privacy Practices ("Notice "). The full text of the Privacy Notice follows this summary.

The Notice informs you of the following:

Uses and Disclosures

We do not need your authorization to use or disclose your PHI when:

- We use it for treatment, payment or health operations,
- You request it, or
- As otherwise permitted under HIPAA, and as explained in detail in the following Notice.

However, your authorization must be obtained before we use or disclose your PHI for all other purposes as required by law.

Your Individual Privacy Rights

Under HIPAA, you have the following rights:

- To request a restriction on the use and disclosure of your PHI, and we will consider whether, and, to what extent, to agree to such a restriction,
- To request to receive confidential communications by alternate means or at alternate locations, and we will accommodate your reasonable requests,
- To inspect and obtain a copy of your PHI that the Fund maintains,
- To obtain an accounting of disclosures of PHI, other than those for treatment, payment or operations, except in limited situations,
- To amend your PHI, as long as the Fund maintains it, subject to certain exceptions.

The Plan's Duties

The Notice explains our obligations to maintain the privacy of your PHI. To that end, we must limit its uses and disclosures of PHI or requests of PHI to the **minimum necessary** to accomplish its purposes, except in limited situations.

Contacting the Plan for Questions or More Information

The Notice explains how you may contact us for these purposes.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO YOU, THE PARTICIPANT, AND TO YOUR ELIGIBLE DEPENDENTS.

Introduction

The Fund is a covered entity within the meaning of the Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA." Under HIPAA, the Fund is legally required to provide you with notice of our legal duties and privacy practices with respect to protected health information ("PHI"). PHI includes any individually identifiable information that relates to your physical or mental health, the health care that you have received or payment for your health care, including name, address, date of birth and Social Security number.

We are legally required to maintain the privacy of your PHI. The primary purpose of this notice is to describe the legally permitted uses and disclosures of PHI, some of which may not apply to this Fund in practice. This notice also describes your right to access and control your PHI.

We are required to abide by the terms of this Notice of Privacy Practices ("Notice"). However, we reserve the right to change the terms of this or any subsequent Notice at any time. If we elect to make a change, the revised Notice will be effective for all PHI that we maintain at that time. Within 60 days of any material revision of our privacy practices, we will distribute a new Notice. Additionally,

you may contact the Fund directly at any time to obtain a copy of the most recent Notice.

Permitted Uses and Disclosures

Treatment means the provision, coordination or management of your health care. As a health Fund, while we do not provide treatment, we may use or disclose your PHI to support the provision, coordination or management of your care. For example, we may disclose the fact that you are eligible for benefits to a provider who contacts us to verify your eligibility for benefits under the health Fund.

Payment means activities in connection with processing claims for your health care and collecting contributions as part of the Fund's payment operations. We may need to use or disclose your PHI to determine eligibility for coverage, medical necessity and for utilization review activities. For example, we could disclose your PHI to physicians engaged by the Fund for their medical expertise in order to help us determine medical necessity and eligibility for coverage under the Fund.

We may also disclose your PHI, and your dependents' PHI, on Explanation of Benefits forms ("EOBs") and other payment related correspondence, which are sent to you by the Fund's "Business Associates," such as Empire.

If you appeal a benefit determination on behalf of an eligible dependent, we may disclose PHI related to that appeal to you. If you appeal a benefit determination and you designate an Authorized Representative to act on your behalf, we will disclose PHI related to that appeal to that Authorized Representative.

We may also disclose your PHI to third parties who are known as "Business Associates" that perform various activities (e.g., claims processing, hospital pre-authorization, case management) for us. In such

circumstances, we will have a written contract with the Business Associate, which requires the Business Associate to protect the privacy of your PHI.

Health Care Operations generally means general administrative and business functions that the Fund must perform in order to function as a health Fund. For example, we may need to review your PHI as part of the Fund's efforts to uncover instances of provider abuse and fraud. In addition, we may combine the PHI of many participants or their eligible dependents to help us decide on the services for which we should provide coverage.

Reminders. We may use your PHI to provide you with reminders. For example, we may use your child's date of birth to remind you that you may purchase continuation coverage for your 23-year old child who would otherwise lose coverage under the Fund.

Health-Related Benefits and Services. We may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Disclosure to Trustees of the Fund. We may disclose your PHI to the Trustees of the Fund in connection with appeals that you file following a denial of a benefit claim or a partial payment. In addition, any Trustee may receive PHI if you request that the Trustee assist you in filing or perfecting a claim for benefits under the Fund. Trustees may also receive PHI if necessary for them to fulfill their fiduciary duties with respect to the Fund. Such disclosures will be the minimum necessary to achieve the purpose of the use or disclosure. In accordance with the Fund documents, the Trustees must agree not to use or disclose PHI other than as permitted in this Notice or as required by law and not to use or disclose the PHI with respect to any employment-related actions or decisions or with respect to any other benefit Fund maintained by the Trustees.

Disclosure to Others Involved In Your Care or Payment of Your Care. We may disclose to your spouse or other members of your immediate family, including stepparents who are covered by the Plan, PHI that is directly relevant to such individual's involvement in your health care or payment of your health care, unless you request us in writing not to do so.

In addition, if you seek the assistance of your shop steward or union business agent, or your employer in connection with your enrollment in the Plan or payment of one or more of your health claims, and you are present when that person calls the Fund or visits the Fund Office, and you authorize the Fund to speak to that person, we will disclose to that person your PHI related to your enrollment in the Plan or payment of your health claim. If you are not present or you want us to disclose any other PHI, you will need to sign an Authorization Form for that purpose. (See information on Authorizations later in this section.)

If you want us to disclose your PHI to any other third party, you must authorize us to do so as described in the section "Authorization For Other Uses and Disclosures of Your PHI."

For disclosures of your minor children's PHI, please refer below to the section "Personal Representatives."

Disaster Relief. We may disclose your PHI to any authorized public or private entities assisting in disaster relief efforts.

Personal Representatives. We may disclose your PHI to your Personal Representative in accordance with applicable state law or the Privacy Rule. A Personal Representative is someone authorized by court-order, power of attorney, or a parent of a child, in most cases. In addition, a Personal Representative can exercise your personal rights with respect to PHI. While generally a parent is the Personal

Representative of an unemancipated minor, we will not disclose PHI, other than payment information, in certain situations where not permitted by law.

Required By Law. We may use or disclose your PHI to the extent that we are required to do so by federal, state or local law. You will be notified, if required by law, of any such uses or disclosures.

Public Health. We may disclose your PHI for public health purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of preventing or controlling disease (including communicable diseases), injury or disability. If directed by the public health authority, we may also disclose your PHI to a foreign government agency that is collaborating with the public health authority.

Health Oversight. We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect. We may disclose your PHI to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if we reasonably believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. We will promptly inform you that such a disclosure has been or will be made, unless we reasonably believe that informing you would place you at risk of serious harm, or we'd be informing a Personal

Representative of yours who we reasonably believe is responsible for the abuse, neglect, or injury.

Food and Drug Administration. Our Prescription Benefits Manager may disclose your PHI to a person or company subject to the jurisdiction of the Food and Drug Administration ("FDA") with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity.

Legal Proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, we may disclose your PHI under certain conditions in response to a subpoena, discovery request or other lawful process, in which case, reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to this disclosure.

Law Enforcement. We may also disclose your PHI, if requested by a law enforcement official as part of certain law enforcement activities.

Coroners, Funeral Directors, and Organ Donation. We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or other duties authorized by law. We may also disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

Research. We are permitted to disclose your PHI to researchers when their research has been approved by an institutional review board that has established protocols to ensure the privacy of your PHI. However, the Fund does not routinely disclose PHI to researchers.

Criminal Activity. Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials conducting national security and intelligence activities including the protection of the President.

Workers' Compensation. We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the institution or law enforcement official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

Required Uses and Disclosures. We must make disclosures to you and to the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.

Authorization for Other Uses and Disclosures Of Your PHI. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted by law as described above. If you authorize us to

use or disclose your PHI for purposes other than set forth in this Notice, you may revoke that authorization, in writing, at any time, except to the extent that we have already taken action based upon the authorization. Thereafter, we will no longer use or disclose your PHI for the reasons covered by your written authorization.

Your Rights

Right to Inspect and Copy. As long as we maintain it, you may inspect and obtain a copy of your PHI that is contained in a Designated Record Set. "Designated Record Set" means a group of records that comprise the enrollment, payment, claims adjudication, case or medical management record systems maintained by or for the Fund.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

We may decide to deny access to your PHI. Depending on the circumstances, our decision to deny access may be reviewable by a licensed health professional who was not involved in the initial denial of access and who has been designated by the Fund to act as a reviewing official.

To request access to inspect and/or obtain a copy of any of your PHI, contact our Privacy Officer to obtain the appropriate form. We may impose a fee to cover the costs of copying and postage. If you want to inspect your PHI, we will make an appointment for you to come to the Fund Office at a reasonable time during normal business hours.

Right to Request a Restriction of Your PHI. You may ask us in writing on the appropriate form not to use or disclose any part of your PHI for the purposes described above.

It is our policy not to honor any requests to restrict the use or disclosure of your PHI for treatment, payment or health care operations. However, we may honor requests to restrict disclosures of your PHI to spouses or other members of your immediate family.

Right to Request to Receive Confidential Communications From Us by Alternative Means or at an Alternative Location. You may request in writing and we must accommodate your reasonable requests to receive notices, such as an Explanation of Benefits ("EOB"), from us by alternative means or at an alternative location. For example, you can ask that we only contact you at work or by mail or at another address. Contact our Privacy Officer at the address at the end of this section to obtain the appropriate form.

Right to Amend Your PHI. If you believe that PHI that we have about you is incorrect or incomplete, you may request it to be amended. To make a request, contact our Privacy Officer to obtain the form.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment,
- Is accurate and complete, and
- In certain other situations.

If we deny your request for amendment, you have the right to file a written statement of disagreement with us or you can request us to include your request for amendment along with the information sought to be amended if and when we disclose it in the future. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to request an accounting or list of disclosures of your PHI made by the Fund or its Business Associates. We are required to comply with your request except with respect to disclosures:

- Made in connection with your receiving treatment, our payment for such treatment and for health care operations,
- Made to you regarding your own PHI,
- Pursuant to your written authorization,
- To a person involved in your health care or payment of your health care or for other permitted notification purposes, and
- Other limited situations.

To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer. You have the right to receive an accounting of disclosures of PHI made within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2004. The first request within a 12-month period will be free of charge. For additional requests within the 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

Right to Obtain a Paper Copy of This Notice. You may request a paper copy of our Notice at any time.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services at:

Hubert H. Humphrey Building,
200 Independence Avenue S.W.,
Washington, D.C. 20201.

To file a complaint with us, you must submit your complaint in writing to our Privacy Officer at the address below. We will not retaliate against you for filing a complaint.

For Questions or Requests

If you have any questions regarding this Notice or would like to submit a written request as described above, please contact:

Theresa Sotelo
Privacy Officer
Industry and Local 338 Welfare Fund
One Executive Boulevard
Yonkers, NY 10701
1-914-375-0591

Important Information About the Fund

The Employee Retirement Income Security Act of 1974 (ERISA) requires that participants in employee benefit plans receive certain administrative information about their plans and the people who run them. Our Plan is subject to those rules and this section will tell you more about Plan operations.

Name of Plan. The Plan's formal name is the Industry and Local 338 Welfare Fund.

Board of Trustees. The Board of Trustees has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this SPD, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan,
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan,
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan,
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this SPD, the Trust Agreement or other Plan documents,

- Process and approve or deny benefit claims (subject to the provisions of any group insurance policies that may be purchased by the Trustees),
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Board of Trustees shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Board of Trustees may delegate any duties or powers as it deems necessary to carry out the administration of the Plan.

The Board of Trustees also reserves the right in its sole and absolute discretion to amend or terminate the Plan at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan's termination (which might occur if the Union and the employers negotiate the discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and provide that all remaining Plan assets will be used in a manner that best carries out the basic purpose for which the Plan was established. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and union representatives.

Plan Sponsor and Administrator. The Board of Trustees is the Plan Sponsor and the Plan Administrator. Day-to-day administration is handled by a Fund Manager appointed by the Board of Trustees. The Fund Manager can be contacted at:

Fund Manager
Industry and Local 338 Welfare Fund
One Executive Boulevard
Yonkers, NY 10701
1-914-375-0592

Identification Numbers. The "employer identification number" assigned to the Fund by the Internal Revenue Service is 13-1818220. The plan identification number assigned to the Plan by the Board of Trustees, pursuant to IRS instructions, is 501.

Plan Year. The Plan's fiscal year runs from July 1 through June 30.

Type of Plan. Our Plan is known as a "welfare" plan under ERISA. It provides medical, prescription drug, vision, dental, death, disability and accidental death and dismemberment benefits.

Agent for Service of Legal Process. In the event of a legal dispute involving the Plan, legal documents may be served on:

Board of Trustees
Industry and Local 338 Welfare Fund
One Executive Boulevard
Yonkers, New York 10701

Legal process may also be served on any individual Trustee at the Fund Office address.

Collective Bargaining Agreement/contributing employers. The Fund is established and maintained in accordance with one or more collective bargaining agreements. A copy of any such agreement(s) may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for

examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

Source of Contributions. The benefits described in this SPD are provided through employer contributions and, in some cases, employee contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of employees.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses.

Identification of Insurance Companies and Other Entities Guaranteeing Benefits. Disability, Death and Accidental Death and Dismemberment benefits are insured through Amalgamated Life Insurance Company. Contact information for Amalgamated is at the end of this SPD.

Self-Funded Benefits. Currently, hospital, medical, prescription drug, dental, optical, and the TCS referral service are self-funded, which means benefits are paid directly out of Fund assets, rather than through an insurance policy. However, in most of these cases, the Fund has contracted with outside providers to administer these benefits. These entities (and any successors to them) are identified at the end of this SPD.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Industry and Local 338 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your

dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington D.C., 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administration and Contact Information

Benefit	Type of Administration	Type of Funding
Hospital and Medical	Empire BlueCross BlueShield 1-800-553-9603 www.empireblue.com	Self-funded. The Fund pays cost of benefits, which are administered under a contract with Empire.
Prescription Drug	UllicareRx/Medco 1-800-818-6602 Medco Health Home Delivery Pharmacy: 1-800-473-3455 www.merckmedco.com	Self-funded. The Fund pays cost of benefits, which are administered under a contract with UllicareRx/Medco.
Optical Services	National Vision Administrators P.O. Box 2187 Clifton, NJ 07015 1-800-672-7723 www.e-nva.com	Self-funded. The Fund pays the cost of benefits, which are administered under a contract with NVA.
Dental	S.I.D.S. P.O. Box 9005 Lynbrook, NY 11563-9005 1-516-396-5500 1-800-537-1238 www.asonet.com	Self-funded. The Fund pays the cost of benefits, which are administered under a contract with S.I.D.S.
Disability, Life Insurance, and Accidental Death and Dismember-ment	Amalgamated Life 730 Broadway, New York, NY 10003 1-212-539-5000 www.amalgamatedlife.com	Insured and administered through Amalgamated Life.