Local 99 Health and Welfare Fund

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Identification Number 30-0217152	**Type of Plan Administration** All Coverage: Self-Insured Multi-Employer/Employee Benefit Plan
Plan Sponsor Number 501	**Plan Year** January 1 – December 31
Type of Plan Health & Welfare	

Local 99 Section 008
Plan Code L9900-008
May 2024

Important Information About the Health Fund

Notice of Grandfathered Status of the Fund

The Fund believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund's Contract Administrator, 703 McCarter Highway, Newark, NJ 07102; Phone: 973-735-6464, Fax: 973-735-6465. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This document constitutes the Summary Plan Description ("SPD") as required by Section 102 of the Employee Retirement Income Security Act of 1974 ("ERISA") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan. The important details about the Health & Welfare Fund and the terms of the Plan are set forth in this SPD. The SPD and other documents including the collective bargaining agreements and the Trust Agreement are intended to constitute the official Plan Document. Every effort has been made to ensure the accuracy of the information provided in this SPD. In the event of a discrepancy between this SPD, and any other documents (including the collective bargaining agreement(s) between your employer and the Union and the Trust Agreement), this SPD will govern.

The SPD is not a contract of employment between you and your employer; it neither guarantees employment or continued employment with your employer or any contributing employer, nor diminishes in any way the right of contributing employers to terminate the employment of any employee. Further, the receipt of this SPD does not automatically entitle you to Plan benefits. To be entitled to benefits you (and your dependents) must meet the requirements for eligibility under the Plan. The Board of Trustees may amend or terminate the Plan, in whole or in part, at any time and for any reason.

How To Use This Booklet

The Plan described in this booklet is effective for participants of the Fund who are covered by Collective Bargaining or Participation Agreements which provide for the appropriate contributions for this coverage.

This booklet is called a Summary Plan Description (SPD). This Summary Plan Description is designed to describe the benefits which are provided by the Health and Welfare Fund and to inform you of your rights under the Health and Welfare Fund and the Employee Retirement Income Security Act of 1974. Although extreme care has been taken to provide accurate information in this Summary Plan Description, it is important for you to understand that if any of the terms in this Summary Plan Description are inconsistent with any of the terms of the Agreement and Declaration of Trust ("Trust Agreement"), the terms of the Trust Agreement control.

You should review this Summary Plan Description and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions section. While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan. No individuals other than the Board of Trustees have any authority to interpret the Plan or to make any promises to you about it.

To assist you in understanding the benefits under the Fund, there are Overview and Summary charts throughout this Summary Plan Description. However, it is important for you to read the entire Summary Plan Description for you to fully understand the benefits that you are entitled to receive under the Plan.

We have tried to write this Summary Plan Description in language that you can easily understand. If you have questions, feel free to call the Contract Administrator, whose name, address and telephone number are listed on page one.

You should also be aware that while the Board of Trustees intends to continue the benefits described in this booklet indefinitely, the Trustees reserve the right to amend or terminate this Plan, or any part of it at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan. To be sure you are covered, and for up-to-date information about the benefits, contact the Fund Office at 703 McCarter Highway, Newark, NJ 07102, Telephone (973) 735-6464.

IMPORTANT

THE CONTRACT ADMINISTRATOR MUST BE TIMELY NOTIFIED IF YOU CHANGE YOUR ADDRESS OR YOU NEED TO ADD OR REMOVE A DEPENDENT. FAILURE TO NOTIFY THE CONTRACT ADMINISTRATOR OF SUCH CHANGES COULD JEOPARDIZE YOUR ELIGIBILITY FOR BENEFITS.

Please put this Summary Plan Description in a safe place for your future reference. Notices of changes (called Summaries of Material Modifications) will be sent to you as the Summary Plan Description is amended or revised. Please review any Summaries of Material Modifications with your covered dependents and keep with your Summary Plan Description.

Important Contact Information

The organizations responsible for administering the Plan can be contacted at the addresses and telephone numbers listed below:

Contract Administrator ▪ Eligibility ▪ Direct Vision Reimbursement ▪ COBRA Continuation Coverage	**Laundry Distribution and Food Service Joint Board** 703 McCarter Highway Newark, NJ 07102 (973) 735-6464
Claims Administrator ▪ Medical Post-Service Claims ▪ Hospital Post-Service Claims ▪ Appeals of Post-Service Claims	**Amalgamated Employee Benefits Administrators** 333 Westchester Ave. White Plains, NY 10604 **Amalgamated Employee Benefit Administrators Appeals Department** 333 Westchester Avenue White Plains, NY 10604
Medical Care Management ▪ Urgent Care Claims ▪ Concurrent Care Claims ▪ Pre-Service Medical, Hospital, and Drug Claims ▪ Appeals involving Pre-Service, Urgent Care, or Concurrent Care Claims	**Amalgamated Medical Care Management** 1 Northeastern Blvd., Suite 100 Salem, NH 03079 **Amalgamated Medical Care Management Attention: Appeals** 1 Northeastern Blvd., Suite 100 Salem, NH 03079
Vision Care Benefits ▪ Participating Vision Centers ▪ Direct Member Reimbursement	**Vision Screening** (631) 467-4515 www.vscreening.com **Local 99 Health & Welfare Fund** 703 McCarter Highway Newark, NJ 07102 (973) 735-6464

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Definitions

Allowed Amount	Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the Allowed Amount, you may have to pay the difference. (See Balance Billing)
Appeal	A request to review a decision that denies a benefit or payment.
Authorized Representative	Somone who you choose to act on your behalf, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf. The Plan requires you to provide a written statement declaring your designation of an authorized representative, along with the representative's name, address, phone number, and email address. If you are unable to provide a written statement, the Plan will require proof that the proposed authorized representative has the power of attorney for health care purposes (e.g., notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal spouse, parent, grandparent, or child over the age of 18).
Balance Billing	When a provider bills you for the difference between the provider's charge and the Allowed Amount. For example, if the provider's charge is $100 and the Allowed Amount is $70, the provider may bill you for the remaining $30. A Participating Provider may not Balance Bill you for covered services.

Behavioral Health/ Mental Health	Treatment for a Mental or Nervous Condition including services for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be deemed Medically Necessary if the treatment is (1) consistent with the diagnosis and treatment of the patient's condition; (2) in accordance with good medical practice; (3) required for reasons other than the convenience of the patient or provider; and (4) the most appropriate level of service or supply that can safely be provided for the patient.
Certified IDR Entity	An entity responsible for conducting and making determinations pursuant to the independent dispute resolution ("IDR") process required by the No Surprises Act and that has been properly certified by the United States Department of Health and Human Services, Department of Labor, and Department of the Treasury.
Coinsurance	Your share of the cost of a covered health care service, calculated as a percent (for example, 10%) of the Allowed Amount for the service.
Copayment or Copay	A fixed amount (for example $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Continuing Care Patient	An individual who, with respect to a provider or facility— (a) is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility; (b) is undergoing a course of institutional or inpatient care from the provider or facility; (c) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery; (d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (e) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Contract Administrator or Administrator	The day-to-day administration of the Fund is performed by the "Contract Administrator" or "Administrator," to whom the Board has delegated some of its duties. The Contract Administrator which has been hired by the Board of Trustees is Laundry Distribution and Food Service Joint Board.
Covered Person	An Employee and that person's eligible Dependent Spouse or Dependent Child who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.
Deductible	The amount of medical expenses for which you are responsible before the Plan will begin to pay benefits on your behalf.
Dependent/Dependent Spouse/Dependent Child	A child or spouse of the Employee who meets the definition of "Dependent" found in the Who Is Covered section of this document.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Emergency Services	Emergency Services with respect to an Emergency Medical Condition, shall mean: (a) a medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (b) within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
Employee	A person employed by an Employer who is a signatory to a Collective Bargaining Agreement, or any other written agreement with the Union or Fund requiring contributions to the Fund for health coverage.
Employer	An Employer signatory to a Collective Bargaining Agreement, or any other agreement with the Union or Fund requiring contributions to the Fund for health coverage.
Excluded Services	Health care services that the Plan does not pay for.
Fund	The Local 99 Health & Welfare Fund
Fund Assets/Plan Assets	The trust of the Local 99 Health and Welfare Fund, including Employer and Employee contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), all increments, earnings and profits therefrom, and any and all other property or funds received and held by the Trustees by reason of their acceptance of the Trust Agreement

Health Care Facility	A Health Care Facility includes the following locations and suppliers, but only when they are 1) licensed to practice where the care is rendered; 2) rendering a service within the scope of that license; and 3) providing a service for which benefits are specifically provided by the Plan: 1) Ambulatory Surgical Center 2) Comprehensive Rehabilitation Facility 3) End-Stage Renal Disease Facility (Dialysis Center) 4) Free-Standing Diagnostic Centers 5) Home Health Care Agency 6) Hospice 7) Laboratory 8) Skilled Nursing Facility 9) Durable Medical Equipment Supplier
Health Care Professional	A Health Care Professional includes the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, is providing a service for which benefits are specifically provided by the Plan, and when benefits would be payable if the services were provided by a Physician: 1) Behavioral Health Practitioner 2) Certified Registered Nurse Anesthetist (CRNA) 3) Certified Social Worker (CSW) 4) Chiropractor 5) Clinical Specialist Psychiatric Registered Nurse 6) Doctor of Physical Therapy (DPT), Physical Therapist, Occupational Therapist, and Speech Therapist 7) Mental health or substance abuse counselor or social worker who has a Master's degree 8) Nurse Practitioner* 9) Nurse Midwife* 10) Physician Assistant* 11) Podiatrist Providers which are asterisked (*) are covered only when practicing under the supervision of an M.D.)

Hospital	A class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which: 1) provides care and treatment by Physicians and nurses on a 24-hour basis for illness or injury through medical, surgical, and diagnostic facilities on its premises; and 2) provides diagnosis and treatment on an inpatient basis for compensation; and 3) is approved by Medicare as a Hospital. The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include facilities for mental health or substance use disorder treatment that are licensed and operated according to law.
Hospitalization	Care in a hospital that requires an admission as inpatient and usually requires an overnight stay. An overnight stay for observation could be considered outpatient care.
Hospital Outpatient Care	Care in a hospital that usually does not require an overnight stay.
Independent Freestanding Emergency Department	A health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides Emergency Services.
Injury/Illness	An abnormal condition or disorder. Injuries include, but are not limited to, fractures, cuts, sprains, and burns. Illness can be sudden or chronic.
Medical Necessity or Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Network	The facilities, providers, and suppliers your Plan has contracted with to provide health care services
Nonparticipating Emergency Facility or Out-of-Network Emergency Facility	An emergency department of a hospital, or an Independent Freestanding Emergency Department, that does not have a contractual relationship directly or indirectly with the Plan for furnishing such item or service under the Plan.

Nonparticipating Provider or Out-of-Network Provider	A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the Plan for furnishing such item or service under the Plan.
Participant	An Employee or Dependent who meets the eligibility rules described in this document
Participating Emergency Facility or In-Network Emergency Facility	An Independent Freestanding Emergency Department, that has a contractual relationship directly or indirectly with the Plan with respect to the furnishing of such an item or service at such facility.
Participating Provider or In-Network Provider	A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the Plan for furnishing such item or service under the Plan.
Physician	A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who: 1. acts within the scope of his or her license; and 2. is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.
Physician Services	Health care services a licensed Physician provides or coordinates
Plan	The benefits and provisions of the Local 99 Health and Welfare Fund's Section 008 plan as described in this document.
Plan Administrator	The Board of Trustees of the Local 99 Health and Welfare Fund.
Plan Year	The twelve-month period beginning January 1 and ending December 31.

Pre-Certification or Prior Authorization	A decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. Pre-Certification is required for a number of services before you receive them, except in an emergency. Pre-Certification is not a promise that the Plan will cover the cost of such an item or service.
Provider	A Physician, Hospital, Health Care Professional or Health Care Facility licensed, certified or accredited as required by state law.
Qualifying Payment Amount	The median of the contracted rates recognized by the Plan for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state All-Payer Claims Database or, if unavailable, any eligible third-party database in accordance with applicable law.
Reasonable & Customary	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.
Recognized Amount	Recognized Amount shall mean (a) an amount determined under an applicable All-Payer Model Agreement, or if unavailable; (b) an amount determined by applicable State law (if applicable); and (c) if no such amounts are available or applicable the lesser of a Provider's billed charge or the Qualifying Payment Amount.
Serious and Complex Condition	A Serious and Complex Condition means (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, a condition that— (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

Substance Use Disorder	Symptoms and conditions identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting from the use of drugs and/or alcohol and/or continuous use in spite of adverse effects (inability to control use, interference with daily functioning, and/or failure to meet major responsibilities at work, school, or home). Treatment for a Substance Use Disorder identified in the current edition of the DSM will be deemed Medically Necessary if the treatment is (1) consistent with the diagnosis and treatment of the patient's condition; (2) in accordance with good medical practice; (3) required for reasons other than the convenience of the patient or provider; and (4) the most appropriate level of service or supply that can safely be provided for the patient.
Union	Laundry Distribution and Food Service Joint Board
Urgent Care	Care for an illness or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Your Plan At A Glance

A Quick Reference For Plan Highlights

Refer to the Section titled Health Care Coverage for benefit details.

By using the Anthem Blue Cross Blue Shield ("BCBS") PPO Network of hospitals, doctors, and other health care providers, you will be entitled to maximum health care coverage for yourself and your family. The chart below summarizes that coverage and is included here as a "quick reference."

Health Care Coverage (For You And Your Covered Dependents)

	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Lifetime Maximum	None	None
Annual Maximum	None	None
Annual Deductible	None	$150 per person, $300 per family
Hospital Inpatient Coverage		
Hospital Inpatient Room, Board, and Ancillary	100% of the hospital network rate up to 120 days per confinement.	In-Network Benefit Only
Mental Health /Behavioral Health Confinements	100% of the hospital network rate up to 120 days per confinement.	In-Network Benefit Only
Substance Use Disorder Confinements	100% of the hospital network rate up to 120 days per confinement.	In-Network Benefit Only
Rehabilitation/Skilled Nursing Confinements	100% of the facility network rate for up to 30 days per year.	In-Network Benefit Only
Home Health Care, including home infusion therapy	100% of the network rate for 90 visits per calendar year.	In-Network Benefit Only
Hospice (Respite Care is not covered)	100% of the network rate. Covered in lieu of hospitalization.	In-Network Benefit Only
Birthing Center	100% of the network rate.	In-Network Benefit Only
Outpatient Surgical Coverage (All services require precertification approval by AMCM.)		
Ambulatory Surgical Center	100% of the facility network rate.	40% or reasonable charges payable at 80%, subject to the annual deductible.
Outpatient Hospital Surgery	100% of the facility network rate.	In-Network Benefit Only
Surgical Treatment of Morbid Obesity	100% of the facility network rate.	In-Network Benefit Only

Hospital Outpatient Coverage	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Emergency Accident, Emergency Illness (If admitted, Pre-Certification is required within 24 hours of admission)	100% of the hospital network rate after a $50 copay. Copay is waived if admitted.	Same as In-Network
Chemotherapy (infusion only), Radiation Therapy, **Respiratory Therapy** (Pre-Certification Required)	100% of the hospital network rate	In-Network Benefit Only
Pre-Admission Testing (services performed within 7 days of admission or surgery)	100% of the hospital network rate	In-Network Benefit Only
Outpatient Therapy **(includes Physical Therapy, Occupational Therapy, Behavioral Health, and Substance Use Disorders)**	Covered only when approved by AMCM. If approved, 100% of the hospital network rate for 30 visits per calendar year (combined facility & professional services).	In-Network Benefit Only
Outpatient Cardiac Rehabilitation	Covered only when approved by AMCM. If approved, 100% of the hospital network rate for 30 visits per calendar year (combined facility & professional services).	In-Network Benefit Only
Outpatient Kidney Dialysis (Pre-Certification Required)	Covered only when approved by AMCM. If approved, 100% of the hospital network rate, subject to a maximum payment of $1,500 per day.	In-Network Benefit Only
Outpatient Diagnostic X-Rays and Laboratory Tests	100% of the hospital network rate.	In-Network Benefit Only
Outpatient MRI and CT Scan **(Pre-Certification Required)**	Covered only when approved by AMCM. If approved, 100% of the hospital network rate.	In-Network Benefit Only

Medical Coverage	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Allergy Testing & Treatment	Allergy testing is covered at 100% of the network rate after a $10 copayment per visit. Allergy treatment is covered at 100% of the network rate (no copay).	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Ambulance	100% of the network rate up to $750 maximum per episode.	Covered at 100% of charges up to $750 maximum per episode.
Anesthesiology	100% of the network rate	80% of Reasonable and Customary charges. See "***Your Rights Against Surprise Medical Bills***" section for claims related to an Emergency Medical Condition.
Bereavement Counseling	100% of the network rate. Limited to 3 sessions per loss.	In-Network Benefit Only
Blood Storage and Processing	100% of the network rate	In-Network Benefit Only
Cardiac Rehabilitation, including professional fees and free-standing facility (Pre-Certification Required)	100% of the network rate after a $10 copayment per visit for 30 visits per calendar year. (Visits for facility and professional services are combined.)	In-Network Benefit Only
Chiropractic Care - Exams and Manipulations (Pre-Certification Required)	100% of the network rate after a $10 copayment per visit. Limited to 30 visits per calendar year.	In-Network Benefit Only
Chiropractic Care – X-Rays	100% of the network rate	In-Network Benefit Only
Dental Treatment Treatment for oral tumors, cysts, bony impacted teeth & accidental injury to sound natural teeth within 12 months of injury. (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Diabetic/Nutritional Counseling	Covered at 100% of the network rate. Limited to 3 visits per year.	In-Network Benefit Only
Diagnostic X-Rays and Laboratory Tests, including professional fees & free-standing facility	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.

Medical Coverage (continued)	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Injections (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Injections – Pain Management (Pre-Certification Required)	100% of the network rate	In-Network Benefit Only
IV Therapy (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Kidney Dialysis, including professional fees and free-standing facility (Pre-Certification Required)	100% of the network rate, subject to a maximum payment of $1,500 per day.	In-Network Benefit Only
Medical Supplies, Equipment & Prosthetics (Pre-Certification Required for all rentals and any purchase in excess of $1,000)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
MRI and CT Scan, including professional fees and free-standing facility (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Orthotics (Pre-Certification Required)	100% of the network rate. Replacement is limited to once every two years.	80% of the BCBS Out-of-Network Rate, subject to the annual deductible. Replacement is limited to once every two years.
Physical and Occupational Therapy, including professional fees and freestanding facility (Pre-Certification Required)	100% of the network rate, after a $10 copayment per visit. Limited to 30 visits per calendar year. (Visits for facility and professional services are combined.)	In-Network Benefit Only
Physician Visits (In Hospital)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Physician Home/Office Visits	100% of the network rate, after a $10 copayment per visit.	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Physician Consultation – Inpatient	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Physician Consultation – Office/Outpatient	100% of the network rate, after a $10 copayment per visit.	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.

Medical Coverage (continued)	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Physician Emergency Room Visits for Medical Emergency	100% of the network rate	Same as In-Network
Podiatry (Foot Care)[1] Bone surgery related to bunions, spurs, and hammertoes is covered. Removal of ingrown toenails for diabetic patients only. (Routine care not covered) (Pre-Certification Required[1])	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Psychotherapy – Outpatient Professional Services (Pre-Certification Required)	100% of the network rate, after a $10 copayment per visit. Limited to 30 visits per calendar year.	In-Network Benefit Only
Radiation and Chemotherapy, Professional Fees (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Respiratory Treatment	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Preventive: Annual Eye Exam	100% of the network rate. Limited to one exam and one refraction per calendar year.	In-Network Benefit Only
Preventive: Annual Physical Exam	100% of the network rate. Limited to one exam per calendar year.	In-Network Benefit Only
Preventive: Immunizations	100% of the network rate	In-Network Benefit Only
Preventive: Routine GYN Exam	100% of the network rate. Limited to 1 per calendar year, unless Medically Necessary.	In-Network Benefit Only
Preventive: Routine Mammography	100% of the network rate. Limited to 1 per calendar year age 40 and over, unless Medically Necessary.	In-Network Benefit Only
Preventive: Pap Smear	100% of the network rate. Limited to 1 per calendar year, unless Medically Necessary.	In-Network Benefit Only

[1] Foot care for diabetic patients provided in an office setting does not require pre-certification.

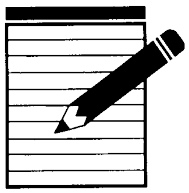
Medical Coverage (continued)	Coverage When A Participating Provider Is Used	Coverage When A Participating Provider is NOT Used
Preventive: Routine Prostate Cancer Screening	100% of the network rate. Limited to 1 per calendar year, unless Medically Necessary.	In-Network Benefit Only
Preventive: Well Child Care	100% of the network rate	In-Network Benefit Only
Second Surgical Opinion	100% of the network rate after a $10 copayment per visit.	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Substance Use Disorder (Pre-Certification Required)	100% of the network rate after a $10 copayment per visit. Limited to 30 visits per calendar year.	In-Network Benefit Only
Surgery (Pre-Certification Required)	100% of the network rate	80% of the BCBS Out-of-Network Rate, subject to the annual deductible.
Organ Transplant (Pre-Certification Required)	100% of the network rate	In-Network Benefit Only

Medical Certification Program — The Medical Certification Program requires that you call Amalgamated Medical Care Management (AMCM) at 1-800-423-9525 to obtain approval before you or one of your covered dependents use any of the services below. In general, precertification should be completed 15 days prior to the service or within 24 hours of an emergency admission.

- If you are going into the hospital or within 24 hours of an emergency admission
- If you are going to be overnight in a hospital
- If you are going to be confined or transferred to a rehabilitation/skilled nursing facility or hospice
- If you are going to have home health care or home infusion therapy
- If you are going to have surgery in an outpatient hospital or ambulatory surgical center
- If you are told you require an organ or tissue transplant
- If you require therapeutic injections
- If you are going to have pain management services
- If you require chronic care treatment, including dialysis, chemotherapy, and radiation therapy
- If you are going to have therapy, including physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, chiropractic care, psychotherapy, and/or substance use disorder treatment
- If you are going to have an MRI, CT Scan, PET Scan or similar procedure
- If you are going to have a sleep study
- For maternity admission, if your physician has recommended a hospital length of stay:
  - for more than 48 hours following a normal vaginal delivery or
  - more than 96 hours following a Cesarean Section
- If your newborn child is going to be confined to the hospital for more than 48 hours
  Please note: Newborns must be added to the Plan for coverage to extend beyond 48 hours for a vaginal delivery and 96 hours for a caesarean section. Please refer to the section titled "When Eligible Dependents Become Covered for Benefits Under The Plan" for important rules.
- If you need to rent durable medical equipment or purchase durable medical equipment with an estimated cost of $1,000 or more
- If you are having a service that is not on this list and you are unsure if it is a covered service or requires a precertification, call the Contract Administrator at 973-735-6464.

If you do not notify Amalgamated Medical Care Management when required, your claims for those services may not be covered, or may not be covered in full. The toll-free telephone number to call Amalgamated Medical Care Management is 800-423-9525.

Basic Information



What Is The Health And Welfare Fund?

The security of your family is an important concern to your employer and your Union. Without adequate protection, the cost of an illness or injury could become a serious financial burden.

Naturally, the hope is that a serious illness or injury never comes your way. However, as a participant of the Plan, you can be assured that you and your family have the protection you need through a wide range of coverage.

Who Pays The Cost Of The Plan?

The Plan is provided pursuant to Collective Bargaining Agreements (CBA) between the Union or a written Participation Agreement between Local 99 Health and Welfare Fund, and various employers and associations of employers, respectively. Employer contributions and all investment earnings are maintained as a Trust Fund, which pays benefits under the Plan. The Plan is self-insured, and benefits are administered jointly by Local 99 Health and Welfare Plan, Amalgamated Employee Benefit Administrators, and Anthem Blue Cross Blue Shield. The cost of the Plan is paid by your employer through regular payments to the Fund, and in some instances, member co-premiums. Information as to whether a particular employer is contributing to the Fund may be obtained by submitting a written request to the Fund Office. A copy of your CBA or Participation Agreement may be obtained upon written request to the Plan Administrator and is available for examination. When you are actively working for an employer and your employer is making payments to the Fund on your behalf, you are considered to be working in covered employment.

Who Is Covered?

You:

When you meet the Plan's requirements for coverage (see the next section).

Your Dependents:

Your eligible dependents include:

- your spouse (if specified in the Collective Bargaining Agreement and/or Participation Agreement; not all employers offer coverage for spouses.);
- your natural children from birth until the end of the month in which they become age 26;
- your adoptive children until the end of the month in which they become age 26;
- children under your legal guardianship until the end of the month in which they become age 26;

The Fund has a right to require you to submit information and documentation to the Fund, either establishing initial proof or continuing proof of a dependent's eligibility for benefits under the Plan.

If your dependents are covered by the Plan as employees, they are not considered covered dependents.

Qualified Medical Child Support Orders:

The Plan will provide health care coverage in accordance with a Qualified Medical Child Support Order, which is any judgment, decree or order issued by a court which recognizes a child or children's right to receive benefits under a group health plan in which the child's parent is an eligible participant.

The Qualified Medical Child Support Order must specify the name and last known mailing address of the participant and the name and address of each of the eligible children, a description of the type of coverage to be provided, the period to which the order applies, and each plan to which the order applies.

The Qualified Medical Child Support Order cannot require the Plan to provide any benefit or option not otherwise provided under the Plan.

When a Qualified Medical Child Support Order is received by the Plan, its receipt will be acknowledged and you will be advised of the Plan's determination of whether it is a Qualified Medical Child Support Order. If you would like to receive a copy of the Plan's procedures with respect to Qualified Medical Child Support Orders, please write to the Plan Administrator and a copy will be sent to you free of charge.

Eligibility For Coverage Under The Plan

Who May Become Eligible Under The Plan

The Plan provides benefits to active participants and, in certain cases, their dependents. Whether or not an employee or a dependent may become eligible for one or more types of benefit coverages depends on the terms of the Plan as described herein and the terms of the applicable Collective Bargaining Agreement and/or Participation Agreement.

How You Become And Remain Covered By The Plan

Initial Eligibility

If you are not currently covered by the Plan as an active participant, you will generally become eligible for benefits under the Plan as an active participant on the first day of the calendar month after you have completed all the following criteria:

- Completion of waiting period. If your Collective Bargaining Agreement and/or Participation Agreement provides for a set waiting period before eligibility is effective, you will not become eligible for any coverage under the Plan until the first of the month following that waiting period has been completed. **The waiting period cannot exceed 60 days since coverage must begin within 90 days of the employee's date of hire.**

- Payment of contributions. Your eligibility to receive benefits will not commence until any employer contributions, and any employee contributions if required by your Collective Bargaining Agreement and/or Participation Agreement, have been made to the Fund.
- Election under employer Cafeteria Plan, if applicable. If, under your Collective Bargaining Agreement and/or Participation Agreement, your eligibility to participate in this Plan is conditioned upon your having in effect a valid election for such coverage under a "Cafeteria Plan" sponsored by your employer, or under a similar election procedure run by your employer, you will also need to have such an election for coverage in effect before you will be eligible for coverage.

Continuation Of Coverage

After you satisfy the initial eligibility requirements set forth above, your coverage will be continued if you satisfy the following continuation of eligibility requirements:

- Employer contributions, and any employee contributions, if required by your Collective Bargaining Agreement and/or Participation Agreement, have been made to the Fund.
- You have not made an election under a Cafeteria Plan sponsored by your employer which terminates your coverage.

Coverage During Leaves of Absence

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 ("FMLA"). Under the FMLA, you may take up to 12 weeks of unpaid leave in a year 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 FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf and your coverage through the Fund will continue.

Your coverage under FMLA will cease once the Contract Administrator is notified (or otherwise determines) that you have terminated employment, exhausted your 12 weeks FMLA leave entitlement, or if you inform the Contract Administrator of your intent not to return from leave. Your coverage will also cease if your employer fails to make contributions required to maintain coverage on your behalf during the 12-week period.

If you do not return to covered employment after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, described below. The qualifying event entitling you to COBRA continuation coverage will be deemed to have occurred on the last day of your FMLA leave.

Call your employer if you have questions regarding your eligibility for FMLA leave. Also call the Contract Administrator regarding coverage during such a leave.

Uniformed Services Employment and Reemployment Rights Act ("USERRA") Leave

If you are on active military duty for 30 days or less, you and your eligible dependents will continue to receive health care coverage under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 30 days, your coverage under the Plan ends, but USERRA permits you to continue health care coverage for you and your eligible dependents at your own expense for up to 24 months. Coverage, for you or your dependents, will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected illnesses or injuries.

This continuation right operates in the same way as COBRA coverage, which is described later in this SPD in the "Your COBRA Rights" section. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the former "CHAMPUS" program). This Plan coordinates its coverage with TRICARE.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment with a Contributing Employer following honorable discharge, provided you return to employment within the time periods prescribed by law (which is generally five (5) years, except in unusual or extraordinary circumstances). If you receive an honorable discharge and return to work with a Contributing Employer your full eligibility will be reinstated on the day you return to work as long as you return within one of the following time frames:

- 90 days of the date of discharge, if the period of service is 180 days or more;
- 14 days from the date of discharge, if the period of service was at least 31 days but less than 180 days; or
- one day after discharge (allowing 8 hours for travel) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended up to two years.

No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service.

Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, for being AWOL, or because of a conviction under court martial would disqualify you from any rights under USERRA.

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 is a good idea for you to also notify the Fund Office.

Reinstatement Of Coverage

If your eligibility for coverage as an active participant has lapsed due to a leave of absence, layoff, disciplinary suspension, the Fund's failure to receive employer and/or employee contributions, or any other grounds for termination of coverage under the Plan, you generally may not again become eligible for coverage under the Plan until after (1) you have returned to covered employment, (2) all required contributions (Employer and Employee, if applicable) have been made, and (3) if you are required under your Collective Bargaining Agreement and/or Participation Agreement to complete a new waiting period, you complete such period. However, if you are returning from a leave of absence under the "Family and Medical Leave Act of 1993," you will not be required to complete a new waiting period.

If your Collective Bargaining Agreement and/or Participation Agreement provides for the date that such reinstated coverage will become effective, your coverage shall be effective on that date. If your Collective Bargaining Agreement and/or Participation Agreement does not provide for such a date, your coverage will be reinstated effective on the first of the month after you satisfy all criteria for reinstatement of coverage.

Upon reinstatement, any amounts that a covered participant previously had accrued toward any annual deductibles or annual visit limitations, will again apply. Participant accumulators do not reset due to a restatement.

When Eligible Dependents Become Covered For Benefits Under The Plan

Initial Eligibility

Any eligible Dependent that you have on the initial date that your coverage becomes effective shall become covered on the same date that you do provided the applicable enrollment materials and proof of eligibility (e.g., birth certificate, marriage certificate, etc.) are timely received by the Fund.

Newly Acquired Dependents

A. **Notification to Fund within 30 days**.

If you are already an active participant of the Fund and you acquire a new dependent after you establish your initial eligibility, or later if so provided under your Collective Bargaining Agreement and/or Participation Agreement, such as through marriage or the birth or placement for adoption of a child, you must immediately notify the Contract Administrator in writing of the new dependent for the new dependent to be covered. If you notify the Contract Administrator within thirty (30) days of the birth, marriage, placement for adoption or other event through which the person becomes your dependent, that dependent shall be eligible for coverage effective on the date of such marriage, birth, adoption or other event.

Note: Adopted children can be added as dependents when the child is placed with you for adoption, if the child is under age 18 at the time of the placement and you assume a legal

obligation for the child's total or partial support in anticipation of adoption, even if the adoption is not yet final.

IF YOU DO NOT COMPLETE AND SUBMIT TO THE PLAN AN ENROLLMENT FORM OR OTHER WRITTEN NOTICE OF ENROLLMENT FOR THE NEW DEPENDENT WITHIN THIRTY (30) DAYS AFTER THE BIRTH, MARRIAGE, ADOPTION OR OTHER EVENT, YOUR DEPENDENT WILL NOT BE ELIGIBLE FOR COVERAGE UNDER THE PLAN UNTIL THE PLAN'S NEXT ANNUAL OPEN ENROLLMENT PERIOD.

You may provide notice of a new dependent by submitting to your Employer a completed Enrollment Form listing the new dependent. If you do not have an Enrollment Form, you may notify the Contract Administrator of the new Dependent in a letter and an official Enrollment Form will be sent to you.

In order to apply for dependent coverage you must submit the following documentation along with the Enrollment Form:

1) Marriage Certificate
2) Birth Certificate and/or Adoption papers for dependent children under age 26
3) Social Security Number for each dependent. Newborns can be added without the Social Security Number, but you must provide the number to the Contract Administrator within sixty (60) days of birth.

B. Special additional rule for Collective Bargaining Agreements and/or Participation Agreements requiring contributions for dependents.

In addition to the above rule concerning the need for timely submitting written notification of enrollment with the Fund, if your Collective Bargaining Agreement and/or Participation Agreement requires additional employer or employee contributions for additional dependents, your new dependent shall not be eligible for coverage until all applicable additional contributions have been made.

C. **Special additional rule if covered by an Employer Cafeteria Plan under which dependent coverage can be elected.**

In addition to the above rules, if the right of your dependents to coverage under this Fund is, under your Collective Bargaining Agreement and/or Participation Agreement, conditioned upon an effective election for such coverage under your Employer's Cafeteria Plan, or under a similar election procedure run by your employer, your dependent will not be eligible for benefits until after there has been a valid election. For an explanation of special "late enrollment" rules under federal law that may allow you to enroll a dependent after the normal deadline under your Employer's Cafeteria Plan procedure in situations in which you acquire a new dependent (e.g., marriage, birth, adoption, etc.) or in which you or a dependent lose coverage under another plan or insurance, see the "Special Enrollment Period" section.

Special Enrollment Period

Under a federal law known as the Health Insurance Portability and Accountability Act ("HIPAA"), plans must permit late enrollments for group health plan coverage in certain situations in which coverage under another plan or insurance is lost, or in which an individual becomes a dependent after the normal enrollment period has closed.

If you decline enrollment for yourself or for a dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- Coverage of a newborn or newly adopted newborn Dependent Child who is properly enrolled within 30 days of birth will become effective as of the child's birth.
- Coverage of a newly adopted Dependent Child or Dependent Child placed for adoption who is properly enrolled within 30 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement of adoption, whichever occurs first.
- Coverage of a Spouse who is properly enrolled within 30 days after the date of your marriage will become effective as of the date of your marriage.

HIPAA further provides for a Special Enrollment Period for group health plan coverage for employees and Dependents (otherwise eligible for coverage) who lose eligibility for Medicaid, SCHIP (State Children's Health Insurance Program), or CHIP (Children's Health Insurance Program), or become eligible to participate in a premium assistance program under Medicaid, SCHIP, or CHIP. A premium assistance program is an optional state program under Medicaid or SCHIP that pays a share of the premium for the group health plan coverage. Under HIPAA, to take advantage of the Medicaid, SCHIP or CHIP right to special enrollment, you must provide timely notice to the Fund of the loss of eligibility for Medicaid, SCHIP, or CHIP coverage or become eligible to participate in a premium assistance program under Medicaid, SCHIP, or CHIP. Notice of the loss of eligibility or becoming eligible to participate in a premium assistance program is to be given by you in writing to the Fund's Contract Administrator within sixty (60) days of the loss of the eligibility for Medicaid, SCHIP, or CHIP coverage or becoming eligible to participate in a premium assistance program under Medicaid, SCHIP, or CHIP. The Special Enrollment following a loss of eligibility for Medicaid, SCHIP, or CHIP coverage or becoming eligible to participate in a premium assistance program then becomes effective the first day of the first month after the notice requesting the change is made.

To request special enrollment, enrollment forms, or to obtain more information about the special enrollment provisions, contact your Employer or the Fund's Contract Administrator.

Changes In Employer Cafeteria Plan Elections

In addition to the rules under HIPAA discussed above, if, under your Collective Bargaining Agreement and/or Participation Agreement, participation in this Plan is by virtue of an election under your Employer's Cafeteria Plan, you may also have the right to make changes in your coverage elections between regular election periods if your Employer's Cafeteria Plan has rules permitting this. Federal tax laws and related regulations regarding Cafeteria Plans permit such plans to have special rules allowing employees to make changes in elective coverages in certain specified circumstances, such as changes in:

- Your legal marital status;
- The number of your dependents;
- Your employment status (or that of your spouse or eligible dependent);
- Your work schedule (or that of your spouse or eligible dependent); or
- Your residence or work site (or that of your spouse or eligible dependent).

You also may be permitted to make changes in your coverage elections in certain situations in which a court order resulting from a divorce, separation, annulment, or legal custody proceeding requires coverage of your child under group health plan benefits, or under the Plan of your former spouse. Similarly, your Employer's Cafeteria Plan may provide special rules allowing you to change your election in certain cases in which coverage for you or a dependent under Medicare or Medicaid is reduced or eliminated or in which you or a dependent become eligible for such coverage.

To determine what, if any, special rules concerning changes in elections your Employer's Cafeteria Plan has, or how to make those changes in elections, you should contact your employer.

How And When You or A Dependent Lose Coverage

How And When Eligibility of An Active Participant Is Terminated

Your eligibility for coverage (other than COBRA coverage under the Fund) terminates on the earliest of the following events:

- You and/or your employer cease or suspend making necessary payments to the Fund in accordance with the relevant Collective Bargaining Agreement, Participation Agreement and/or the payment schedules as established by the Fund.
- You file an election under your Employer's Cafeteria Plan electing to terminate coverage consistent with the terms of the Collective Bargaining Agreement and/or Participation Agreement.
- You and/or your employer fail to timely pay the required premiums or contributions (including COBRA premiums) towards the cost of coverage.

How and When Eligibility for a Dependent is Terminated

Your eligible dependent shall lose eligibility for coverage (other than COBRA coverage) on the earliest of the following events:

- You cease to be a covered participant under the Plan (your eligible dependent's coverage will terminate when your coverage terminates).
- Your dependent ceases to satisfy the Plan's definition of "Dependent."
- You and/or your employer cease or suspend making necessary payments to the Fund in accordance with the relevant Collective Bargaining Agreement, Participation Agreement and/or the payment schedules as established by the Fund.

Election By Active Participants and Dependents To Make Medicare Your Exclusive Coverage

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If you are an active participant and Medicare eligible, or a spouse of an active participant who is Medicare eligible, you may elect to have Medicare as your exclusive form of hospital, medical, surgical, and major medical coverage. If you make this election, you will lose all your coverage for hospital, medical, surgical, and major medical coverage under the Plan because the Plan is prohibited by law from providing you with any benefits that supplement those under Medicare. If you do not make this election, the law requires that the Plan remain your primary coverage for hospital, medical, surgical and major medical benefits, with Medicare being the secondary coverage. If you desire to have Medicare as your exclusive form of coverage for the hospital, medical, surgical and major medical benefits, you must file a written election with the Fund Office.

The choice of a Medicare eligible participant to retain or cancel coverage under this Plan is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

Health Care Coverage

Introduction

The Local 99 Health and Welfare Fund is pleased to provide you with a health and welfare Plan in conjunction with Amalgamated Employee Benefits Administrators and Anthem Blue Cross Blue Shield.

This Preferred Provider Organization (PPO) has been chosen by the Local 99 Health and Welfare Fund Trustees for its excellent reputation in delivering high quality health care, while limiting out-of-pocket medical expenses. These providers all meet the high standards of quality generally accepted in the medical community and will be available to care for you and your family whenever you need medical assistance.

How The Network Works

Participating Providers have agreed to accept the Fund's payment as payment in full, after you pay any required Copayment. If you or your covered dependents use a Participating Provider, your only cost for covered health care charges will be for the Copayment amount, where applicable.

If you do not use a Participating Provider when one is available, you will have a reduced benefit, or possibly no coverage at all. . There are several services that are an In-Network benefit only. Where Out-of-Network coverage is provided, the Fund's payment will be based on a reduced allowance. The charges of some Non-Participating Providers may be more than the Fund's Out-of-Network Allowed Amount. In that case, you may be responsible for the additional amount over the Fund's Allowed Amount. Medical treatment that you or your covered Dependents receive Out-of-Network may be subject to a Deductible and/or Coinsurance. When you receive emergency care or are treated by an Out-of-Network provider at an In-Network hospital or ambulatory surgical center, you may be protected from surprise billing or balance billing. Refer to the section titled "Your Rights and Protections Against Surprise Medical Bills" for additional information.

To find a Participating Provider call 800-810-BLUE or visit the Anthem Blue Cross Blue Shield website at www.anthem.com. When scheduling an appointment, you should always ask if your provider participates with Anthem Blue Cross Blue Shield National PPO (BlueCard PPO) as providers move in and out of networks. Also review the coverage described in this booklet to be sure that benefits are provided by your Plan for the services you select.

What you get when you stay inside the Anthem Blue Cross Blue Shield National PPO Network (BlueCard PPO):

- Access to one of the largest networks of doctors and hospitals throughout the country
- Providers that are continuously reviewed for Anthem Blue Cross Blue Shield's high standards of quality
- Minimal out-of-pocket costs for preventive care as well as a variety of hospital and medical services
- Freedom from completing claims forms
- Coverage for you and your family when travelling or temporarily living outside your service area.

Customer Service

For general questions regarding claims or benefits, contact Amalgamated Employee Benefits Administrators at 800-423-9525.

The Contract Administrator has dedicated staff to support Plan Participants. Staff can be reached Monday through Friday from 9:00 to 5:00 at 973-735-6464. Call the Contract Administrator any time you have questions regarding the Plan or how to access care. A few examples of the types of issues they can assist with include:

- Address and phone number changes
- Claims issues or payment disputes, including collection notices
- Coverage verification for specific procedures or services
- Detailed benefit information
- Eligibility updates
- Insurance identification cards

Amalgamated Medical Care Management

Your good health and the good health of your family is one of the most important things you can have. The Fund provides many benefits that help you cover costs when you are sick, but also wants to help you get well and stay well. There are many programs that can assist you in that effort. Through Amalgamated Medical Care Management, the Fund has nurses, doctors, case managers and health coaches who are there to provide you with assistance and support. These programs are completely free to you and your family. For more information, the toll-free telephone number to call Amalgamated Medical Care Management is 800-423-9525.

Medical Certification Program

The Medical Certification Program is a cooperative effort in which the Fund's medical professionals work with you, your family, your doctor and hospital to assure you of the highest quality care and to help avoid unnecessary days in the hospital and other unnecessary medical treatment.

The Medical Certification Program requires that you and your covered dependents call Amalgamated Medical Care Management at 800-423-9525 if you experience any of the situations below. In general, pre-certification should be completed 15 days prior to the service or within 24 hours after an emergency admission. If you do not notify Amalgamated Medical Care Management when required, your claims for those services may not be covered, or may not be covered in full.

- If you are going into the hospital or within 24 hours of an emergency admission.
- If you are going to be overnight in a hospital.
- If you are going to be confined or transferred to a rehabilitation/skilled nursing facility or hospice.
- If you are going to have home health care or home infusion therapy.
- If you are going to have surgery in an outpatient hospital or ambulatory surgical center.
- If you are told you require an organ or tissue transplant.
- If you require therapeutic injections.
- If you are going to have pain management services.
- If you require chronic care treatment, including dialysis, chemotherapy, and radiation therapy.
- If you are going to have therapy, including physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, chiropractic care, psychotherapy, and substance use disorder treatment.
- If you are going to have an MRI, CT Scan, PET Scan or similar procedure.
- If you are going to have a sleep study.

- For maternity admission, if your physician has recommended a hospital length of stay:
  - for more than 48 hours following a normal vaginal delivery or
  - more than 96 hours following a Cesarean Section.
- If your newborn child is going to be confined to the hospital for more than 48 hours.

  Please note: Newborns must be added to the plan for coverage to extend beyond 48 hours for a vaginal delivery and 96 hours for a caesarean section. Please refer to the section titled "When Eligible Dependents Become Covered for Benefits Under The Plan" for important rules.
- If you need to rent durable medical equipment or purchase durable medical equipment with an estimated cost of $1,000 or more.
- If you are having a service that is not on this list and you are unsure if it is a covered service or requires a precertification, call the Contract Administrator at 973-735-6464.

Amalgamated Medical Care Management's doctors and/or nurses will contact your doctor and your hospital to provide a professional review of your treatment and determine whether the care you receive is Medically Necessary and delivered in the appropriate setting for your treatment.

If Amalgamated Medical Care Management determines that your proposed treatment is not Medically Necessary, you and your doctor will be advised. If you go ahead with treatment that Amalgamated Medical Care Management determines is unnecessary or is in an inappropriate setting, the Plan will not cover the costs for that part of your care.

The Plan, Plan's administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, Plan's administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

The 24 Hour Nurse HelpLine

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll-free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support and counseling. The Nurse HelpLine nurses will provide you with health information and/or assess your symptoms to ensure you access the right level of care at the right time based on your unique situation. For more information, call the Nurse HelpLine at 1-800-423-9525.

Medical Case Management

If you or a family member has a high cost traumatic injury or illness, you may be contacted by Amalgamated Medical Care Management's registered nurse case managers to assist you and your family. They can work directly with you, your family, the hospitals and physicians to help manage the medical care of the patient. They can help make arrangements with providers and enable youand your family to explore all potential health care options and alternatives. The program's services are free to those patients eligible for Plan coverage.

Getting Well, Staying Well Program

Chronic diseases like heart disease, diabetes, back pain, asthma and cancer are often preventable. If you are already affected by a chronic disease, it may be possible to manage it better to improve your quality of life.

The Getting Well, Staying Well program can help you live healthier and feel better. We can help you learn more about treating your existing health conditions and preventing new ones from developing. The program will provide you with a Registered Nurse who will be your personal health coach. They will be your partner to develop a customized program just for you. It is completely up to you to decide if working with a personal health coach can make a difference in your life. **The service is completely confidential and is free to you. This service will not result in any increase in your co-premium (if applicable) unless your Collective Bargaining/Participation Agreement specifies a general increase is required.**

TO GET STARTED

The first step is to complete a health risk assessment. It is a simple set of questions that will help determine what you are doing right for your health and what you may be able to do better. It takes about 15 minutes of your time.

A health risk assessment can be submitted by mail, through a secure weblink, or telephonically with a case manager. For additional information or to complete a health risk assessment, call Amalgamated Medical Care Management at **866-663-7486**.

After you complete the health risk assessment by computer, by mail, or by phone, a nurse health coach will contact you to review the results and discuss your options.

GETTING WELL

If you have a chronic medical condition like diabetes,-asthma, heart disease, back pain or cancer, a personal health coach can help you obtain your medications, monitor your condition and work with you on ways to stabilize and improve your health. They will work with you and your doctor to develop a program that is right for you and then help you stick to the program.

STAYING WELL

You may be feeling fine now but you might have some risk factors or behaviors that could lead to illness later in life. A personal health coach can help you understand those risks and teach you how to make simple changes that can prevent illnesses from developing. The personal health coach will develop a plan that is right for you and be a resource for your questions and concerns.

DO YOU WANT TO STOP SMOKING?

We know it is hard to quit smoking, but four million people die every year from tobacco related causes. You don't want to be one of them. A personal health coach can help you with proven strategies to quit smoking. Your personal health coach will be there for you to provide daily support.

DO YOU WANT TO LOSE WEIGHT?

A personal health coach can work with you to find the weight loss method that works best for you. Ongoing support makes the tough road of losing weight a little easier.

IF YOU HAVE ACCESS TO A COMPUTER

Take the Health Risk Assessment online. You'll get immediate feedback about your health risks and the option to set up a discussion with a nurse health coach. On the ***Getting Well, Staying Well*** website, there is lots of health information on different health topics for you to explore.

IF YOU DON'T HAVE ACCESS TO A COMPUTER

Mail in the health risk assessment form or call **1-866-663-7486**. A health coach will get in touch with you. If you don't have computer access, your health coach can also mail health information to you.

Remember, it's free, it's confidential, and it can help you live a longer, healthier life. Take the Health Risk Assessment and sign up to get a Registered Nurse Personal Health Coach from Amalgamated Medical Care Management, an affiliate company of the Amalgamated Family of Companies.

Lifetime Maximum Payment

There is no lifetime maximum payment under the Plan.

Calendar Year Maximum Payment

There is no calendar year maximum payment under the Plan.

Your Deductible And Coinsurance

IF YOU USE A PARTICIPATING PROVIDER there is no Deductible or Coinsurance. Copayments apply to some benefits, such as therapy visits.

IF YOU DO NOT USE A PARTICIPATING PROVIDER the Deductible and Coinsurance apply to some of your coverage.

During the calendar year (January 1 through December 31), before there is any reimbursement of your health care expenses from the Fund, you must first incur $150 in eligible medical expenses. This is called the Deductible. Only one annual Deductible of $150 per person or $300 per family is applied to your Out-of-Network coverage.

When the Deductible has been met, in general the Plan will pay 80% of the Out-of-Network Allowed Amount. The 20% of the Allowed Amount that your Plan does not pay is called the Coinsurance, and it is your responsibility. Coinsurance is in addition to any Balance Billing that may be charged by the Out-of-Network provider. Using an Out-of-Network provider will result in a substantially reduced benefit and higher out of pocket expenses for you.

Hospital Inpatient Coverage

All Fund participants and their covered dependents who are going into the hospital must notify Amalgamated Medical Care Management at least 15 days prior to the admission, or as soon as the admission date has been scheduled. If the admission is an emergency, contact Amalgamated Medical Care Management within 24 hours of the admission. If you are unable to call within 24 hours, call as soon as possible after the admission. Failure to call may result in a reduction in coverage.

Medical/Surgical Inpatient Confinements

Hospital inpatient facilities and hospital billed services and supplies are covered for up to 120 days per confinement. Coverage is provided for:

- semi-private room and board
- the intensive care unit (ICU), coronary care unit (CCU), and a certified Medically Necessary private room

- private room, when certified as Medically Necessary or when a semi-private room is not available.
- premature nursery care for infants who weigh less than 5.5 pounds
- ancillary services and supplies billed by the hospital, including:
- laboratory tests;
- X-rays;
- use of operating and recovery rooms;
- use of equipment for blood transfusions; and
- most other services and supplies a hospital normally provides for its patients.

Coverage is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.

  Note: If you are confined to a Participating hospital and receive services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist, please refer to the "Your Rights Against Surprise Medical Bills" section of this booklet for a description on how such services are covered.

- If you do not use a Participating Provider: Not covered.

Some of the above services may be performed by professionals who are not employees of the hospital and who may bill the patient separately. That is, the charges will not be part of the hospital bill. When this happens, these charges may be covered under your Medical Coverage.

For purposes of the 120 day maximum, successive confinements where there is not a separation of at least 90 days or more between confinements are considered continuous confinements.

Mental Health Confinements

Coverage is provided for hospital inpatient confinements for mental nervous conditions. Coverage is provided for up to 120 days per confinement.

Coverage is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Some of the above services may be performed by professionals who are not employees of the hospital and who may bill the patient separately. That is, the charges will not be part of the hospital bill. When this happens, these charges may be covered under your Medical Coverage.

For purposes of the 120 day maximum, successive confinements where there is not a separation of at least 90 days or more between confinements are considered continuous confinements.

Substance Use Disorder Confinements (Detox & Rehabilitation)

Coverage is provided for hospital inpatient confinements for treatment of Substance Use Disorders. Coverage is provided for up to 120 days per confinement.

Coverage is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

A partial day stay is covered. For purposes of the 120-day limit, two partial days will equal one inpatient day.

Some of the above services may be performed by professionals who are not employees of the hospital and who may bill the patient separately. That is, the charges will not be part of the hospital bill. When this happens, these charges may be covered under your Medical Coverage.

For purposes of the 120 day maximum, successive confinements where there is not a separation of at least 90 days or more between confinements are considered continuous confinements.

Rehabilitation/Skilled Nursing Confinements

Coverage is provided for hospital inpatient confinements for rehabilitation or skilled nursing for up to 30 days per year.

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

A skilled nursing or an acute rehabilitation facility is a specially licensed institution (or part of an institution such as a hospital) which allows patients to recover in an environment devoted to rehabilitation. A skilled nursing or an acute rehabilitation facility is appropriate for patients who need specialized care on a daily basis, but no longer need to be confined to a hospital. Arrangements, including pre-certification, must be made through Amalgamated Medical Care Management at 800-423-9525.

Coverage is provided for short-term rehabilitation during the acute stages of an illness or injury when a physician has determined that therapy will result in a significant improvement in the acute condition within a specified time period.

The Plan pays the agreed upon rate for charges incurred in a skilled nursing or an acute rehabilitation facility providing all the following conditions are met:

- the patient was hospitalized for at least three consecutive days (not including the day of discharge) and within 14 days of transferring to a skilled nursing or acute rehabilitation facility, and
- the patient was transferred to the skilled nursing or acute rehabilitation facility for treatment of the same condition that was treated in the hospital, and
- the patient's doctor must certify that the patient requires daily skilled nursing or acute rehabilitation care, and that the patient's doctor supports the Medical Necessity of that care.
- The day(s) are authorized by Amalgamated Medical Care Management.

Home Health Care

Home health care, when provided by a licensed public or private agency which specializes in providing therapeutic services at home, allows the patient to recover from an illness at home rather than spending unnecessary time in the hospital. Arrangements for home health care services must be pre-certified by calling Amalgamated Medical Care Management at 800-423-9525.

The Plan covers the charges of a home health care agency for up to 90 visits per person per calendar year, provided all the following conditions are met:

- the patient's physician certifies that without home health care a continued hospital or acute rehabilitation facility confinement would be necessary, and
- the patient is confined to home.

The Plan covers the charges of a Participating home health care agency for the following services and supplies:

- professional visits by a registered nurse or licensed practical nurse (not full-time care)
- part time home health aide service (up to four hours of care is equal to one home care visit)
- physical, speech or occupational therapy medical social services under the direction of a physician
- laboratory, x-ray and EKG services for treatment of the illness to the extent they would have been covered if provided in the hospital
- medical supplies which would have been required in the hospital
- use of medical appliances

This benefit also includes Home Infusion Therapy.

Coverage is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate for up to 90 visits per calendar year.
- If you do not use a Participating Provider: Not covered.

Hospice Care

A hospice is a facility or program of care designed to provide comfort and support for persons in the last stages of a terminal illness and their families. Hospice services are usually provided at home, but inpatient care is available where necessary. Hospice care must be pre-certified and arranged by Amalgamated Medical Care Management.

Hospice benefits are provided as long as the patient has been certified by his or her primary attending physician as having a life expectancy of six months or less and care is provided by a state certified hospice.

The Plan covers charges for the following services and supplies provided by a hospice:

- hospital inpatient care
- professional nursing visits (not full-time care)
- home health aide visits
- physical and speech therapy
- occupational therapy
- respiratory therapy and equipment
- physician visits
- laboratory tests and X-rays
- chemotherapy/radiotherapy for symptom control
- prescription drugs (excluding experimental drugs)
- rental of medical equipment
- medical/surgical supplies
- social services

Coverage is provided in lieu of hospitalization, on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Respite Care is not covered.

Bereavement counseling is covered at 100% of the Network rate. Coverage is limited to 3 visits per loss. Services provided by a Non-Participating Provider are not covered.

Birthing Center

A birthing center is a free standing facility or hospital affiliated program which provides maternity care for uncomplicated deliveries. Coverage is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Outpatient Surgery Coverage

All Plan participants and their covered dependents that are going to have surgery must notify Amalgamated Medical Care Management at least 15 days prior to the procedure, or as soon as the surgery has been scheduled. If the surgery is emergent, contact Amalgamated Medical Care Management within 24 hours of the procedure. If you are unable to call within 24 hours, call as soon as possible after the procedure.

Failure to call may result in a reduction in coverage.

Ambulatory Surgical Facility

The Plan covers the charges of an ambulatory surgical center, also known as a surgical-center or short-procedure unit (SPU). If medically necessary surgery is performed in an ambulatory surgical center, coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 40% of reasonable charges payable at 80%, subject to the annual Deductible.

Outpatient Hospital Surgery

If Medically Necessary surgery is performed on an outpatient basis, coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Hospital Outpatient Coverage

Coverage is provided for charges for the use of emergency room facilities and other outpatient services and supplies billed by the hospital as described below.

Professional fees which are not billed by the hospital (that is, charges that do not appear on the hospital bill) are not covered under Hospital Outpatient Coverage. Refer to the Medical Coverage section for additional details.

Emergency Treatment

Coverage is provided as follows for the treatment of an Emergency Medical Condition.

- If you use a Participating Provider: Covered at 100% of the Network rate, after a $50 copay. If admitted, Copayment is waived.
- If you do not use a Non-Participating Emergency Facility: Same as In-Network Benefit.

Note: If you receive emergency room services from a professional who is NOT in the Network, while using a Participating hospital, you are covered at 100% of the Recognized Amount.

Treatment in the hospital emergency room or a hospital clinic for a non-emergency illness is not covered.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

In reviewing emergency services, the Plan will consider the details of the claim, including the participant's symptoms and apply the Prudent Layperson Standard, as outlined above. In other words, the participant's symptoms make it an emergency, not the final diagnosis. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an emergency even if the final diagnosis indicates that it was not actually a heart attack.

Pre-Admission Testing

Coverage is provided when testing is performed within 7 days of admission to the same hospital in which the testing is received, as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Network facility: Not covered.

Chemotherapy (infusion only), Radiation Therapy and Respiratory Therapy

Pre-Certification is required through Amalgamated Medical Care Management (AMCM). If AMCM approves, coverage is provided for chemotherapy, radiation therapy, and respiratory therapy in an outpatient hospital as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Outpatient Therapy

Therapy in the outpatient hospital setting, including physical therapy, occupational therapy, Behavioral Health treatment, and Substance Use Disorder treatment is not covered, unless approved by Amalgamated Medical Care Management (AMCM). Coverage is provided in a free standing facility only under Medical coverage.

If AMCM approves the service in the outpatient hospital setting, coverage is provided for a maximum of 30 visits per calendar year (combined with Medical coverage) as follows:

- If you use a Participating Provider: Covered at 100% of the hospital rate.
- If you do not use a Participating Provider: Not covered.

Outpatient Speech Therapy

Therapy in the outpatient hospital setting is not covered, unless approved by Amalgamated Medical Care Management (AMCM). Coverage is provided in a free standing facility only under Medical coverage.

If AMCM approves the service in the outpatient hospital setting, coverage is provided for a maximum of 30 visits per calendar year (combined with Medical coverage) as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Speech therapy must be ordered by a physician and follow either:

(1) surgery for correction of congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person;

(2) an injury;

(3) a sickness.

Outpatient Cardiac Rehabilitation

Pre-Certification is required through Amalgamated Medical Care Management (AMCM). If AMCM approves, coverage is provided for cardiac rehabilitation in the outpatient department as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Coverage is provided for a maximum of 30 visits per calendar year (combined with Medical coverage).

Outpatient MRI and CT Scan

Precertification is required through Amalgamated Medical Care Management (AMCM). If AMCM approves, coverage is provided for MRI, CT Scan, PET Scan, nuclear medicine, and other comprehensive diagnostic procedures in the outpatient department as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Outpatient Diagnostic X-Rays and Laboratory Tests

Coverage is provided for diagnostic x-ray and laboratory tests in the outpatient department of a hospital as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Sleep studies are covered under the Plan but the service requires prior approval from Amalgamated Medical Care Management.

Outpatient Kidney Dialysis

Kidney Dialysis in the outpatient hospital setting is not covered, unless approved by Amalgamated Medical Care Management (AMCM). If AMCM approves the service in the outpatient hospital setting, coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate, subject to a maximum payment of $1,500 per day.
- If you do not use a Participating Provider: Not covered.

Services must be provided by a Blue Distinction provider or at Center of Excellence.

Medical Coverage

Allergy Testing

Coverage is provided for allergy testing as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Allergy Treatment

Coverage is provided for allergy treatment and allergy injections (allergen immunotherapy) as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Ambulance Services

Coverage is provided up to $750 per episode per person for Medically Necessary ground transportation by ambulance as follows:

- If you use a Participating Provider: Covered at 100%of the Network rate up to $750 maximum per episode.
- If you do not use a Participating Provider: Covered at 100% of charges up to $750 maximum per episode.

Anesthesiology

Coverage is provided for anesthesiologist or a certified nurse anesthetist services, when provided as part of a covered surgical procedure. Coverage is as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of Reasonable and Customary charges. See "***Your Rights Against Surprise Medical Bills***" section for claims related to an Emergency Medical Condition.

Blood Storage and Processing

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Cardiac Rehabilitation

Coverage is provided for cardiac rehabilitation to a maximum of 30 visits per calendar year (combined with outpatient hospital coverage), including services in a free-standing facility. Pre-Certification is required. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate, after a $10 copayment per visit.
- If you do not use a Participating Provider: Not covered.

Chiropractic Care - Exams and Manipulations

Coverage is provided for chiropractic exams and manipulations up to a maximum of 30 visits per calendar year. Pre-Certification is required. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate, after a $10 copayment per visit.
- If you do not use a Participating Provider: Not covered.

Chiropractic Care - X-Rays

Coverage is provided for chiropractic x-rays as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Dental Treatment

Coverage is provided for treatment of oral tumors, cysts, bony impacted teeth, and accidental injury to sound natural teeth within 12 months of injury. Pre-Certification is required.

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Diabetic and Nutritional Counseling

Coverage is provided for diabetic or nutritional counseling sessions up to a maximum of 3 visits per calendar year. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Diagnostic X-Ray And Laboratory Tests

Coverage is provided for the following diagnostic and laboratory services, including services in an office or free-standing facility:

- diagnostic medical testing
- diagnostic X-rays
- radiology
- pathology

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Genetic testing requires prior approval from AMCM and is limited to molecular pathology and genetic testing for targeted cancer treatment. Covered services must be rendered by a Participating Provider.

Genetic counseling is not covered.

Sleep studies require prior approval from AMCM.

MRI, CT Scan, PET Scan, nuclear medicine, and other comprehensive diagnostic procedures require prior authorization. See additional coverage details in the "MRI & CT Scan" section below.

Family Planning

Coverage is provided for the following services and devices:

- IUD's
- Tubal Ligation
- Vasectomy

Pre-Certification is required. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Infertility treatment, artificial reproduction and reversal of sterilization is not covered.

Injections

Pre-Certification is required. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Note: Injections for pain management are not covered when provided by Out-of-Network providers.

IV Therapy

Pre-Certification is required. Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Kidney Dialysis

Benefits are provided for Kidney Dialysis (hemodialysis or peritoneal dialysis) in a free-standing facility. The cost for rental or purchase of equipment or supplies is also covered. Pre-Certification is required.

Kidney Dialysis is not covered in the outpatient department of a hospital, except if approved by Amalgamated Medical Care Management.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate, subject to a maximum payment of $1,500 per day.
- If you do not use a Participating Provider: Not covered.

Medical Supplies, Durable Medical Equipment and Prosthetics

Coverage is provided for the purchase or rental of Medically Necessary supplies, equipment and prosthetics as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Pre-certification by Amalgamated Medical Care Management is required for any rental (regardless of the monthly expense) and purchases with an estimated cost of $1,000 or more.

Replacement for irreparable damage and/or normal wear is covered once every two years.

MRI and CT Scan

Coverage is provided for MRI and CT Scan, PET Scan, nuclear medicine, and other comprehensive diagnostic procedures, including services in a free-standing facility. Pre-Certification is required.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Orthotics

Corrective appliance must be a device added to the body to stabilize or immobilize a part, prevent a deformity or assist with function; and be semi-rigid and correct a diagnosed musculoskeletal malalignment of a weakened or diseased body part. Diabetic shoes and foot orthotics are covered once every two years when medically prescribed and non-surgical related. Orthopedic shoes and other supportive devices are covered only when they are an integral part of the leg brace. Orthotics require pre-certification. If not listed above, foot orthotics and other supportive devices for the feet are not covered.

Coverage is provided for medically prescribed orthotics, as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Replacement is limited to once every two years due to irreparable damage and/or normal wear or a significant change in medical condition.

Replacement/repair costs due to malicious damage, culpable neglect or wrongful disposition of the equipment/device are not covered.

Physical And Occupational Therapy

Coverage is provided for treatment by a licensed physical therapist or licensed occupational therapist to a maximum of 30 visits (combined physical therapy and occupational therapy visits) per calendar year, including services in a free standing facility. Pre-Certification is required.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Not covered.

Physician Visits While In The Hospital

Coverage is provided for services while in the hospital as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Physician Visits While in the Emergency Room for a Medical Emergency

Coverage is provided for services of an emergency room physician for an emergency medical condition, as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Same as In-Network

Physician Consultation Inpatient

Coverage is provided for physician consultation as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Physician Home and Office Visits

Coverage is provided for home and office visits, including specialists, as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Physician Consultation Office or Outpatient Hospital

Coverage is provided for physician consultation as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate, after a $10 copayment per visit.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Podiatry (Foot Care)

Bone surgery related to bunions, spurs and hammertoes is covered. Removal of ingrown toenails for diabetic patients only. Pre-Certification is required. Routine care is not covered.

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Psychotherapy

Pre-Certification is required. Coverage is provided for up to a maximum of 30 visits per calendar year as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Not covered.

Radiation And Chemotherapy Professional Fees

Pre-Certification is required. Coverage is provided for radiation and chemotherapy professional fee services as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Respiratory Treatment

Coverage is provided for treatment by a licensed therapist for professional services as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Second Surgical Opinion

Coverage is provided for one Second Surgical Opinion per condition for the charges of a physician and any related diagnostic testing for a second surgical opinion prior to surgery.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Substance Use Disorder

Pre-Certification is required. Coverage is provided for up to a maximum of 30 visits per calendar year as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate after a $10 copayment per visit.
- If you do not use a Participating Provider: Not covered.

Surgery

Pre-Certification is required. Coverage is provided for Surgery as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate*.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

*Common industry standard rules are applied when calculating the Allowed Amount. The most common examples are summarized below:

- If a secondary surgical procedure(s) is performed during the same operation through only one route of access, the Plan will cover the primary procedure only. There will be no payment for any other procedures performed at the same time.
- If more than one surgical procedure is performed during the same operation through more than one route of access, the Plan will cover the primary procedure plus 50% of what the Plan would have paid for each of the other procedures had those procedures been performed alone.
- If the surgical procedure(s) are performed by co-surgeons, the Allowed Amount for each surgeon will be reduced to 50% of the Network rate.
- The Plan provides coverage for the Medically Necessary charges of an assistant surgeon if none is available in the hospital or facility where surgery is performed and the surgical assistant is not a hospital employee. Surgical procedure must be approved by Amalgamated Medical Care Management. If approved, the Allowed Amount for the assistant surgeon will be 20% of the Network rate for the primary surgeon. Coverage is limited to one assistant surgeon per surgical procedure. This benefit is paid only to a licensed Physician.

Maternity

Maternity related charges are payable to a physician or certified nurse midwife in accordance with the surgical schedule.

Coverage for Maternity is provided on the following basis:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Covered at 80% of the BCBS Out-of-Network Rate, subject to the annual Deductible.

Organ Transplant Coverage

Requests for coverage for an organ transplant must be submitted to Amalgamated Medical Care Management in writing to obtain prior authorization. Authorized transplants will be covered, subject to the limits of the Plan's coverage. Call 800-423-9525 for the address and to initiate the certification process.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

The following items and services are also specifically excluded:

- Services provided not in accordance with prior authorization.
- Procurement of the organ for transplant, including charges for the preparation and transportation of the organ for transplant.
- An organ that is synthetic, artificial or obtained from other than a human body.
- An organ procurement or organ transplant performed outside the continental United States.
- Prescription drugs, including immunosuppressant drugs, not billed by the hospital during an inpatient confinement.
- Transplants deemed to be experimental, investigational or unproven as determined by Amalgamated Medical Care Management's generally accepted standards of medical practice, or in accordance with government guidelines.

Preventive Services

The following is a list of preventive services that are covered in full if you use a Participating Provider. If you do not use a Participating Provider, the services are not covered.

Annual Eye Exam

Coverage is provided for one routine eye exam and one refraction per person per calendar year.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Annual Physical Exam

Coverage is provided for the charges of a physician and any related diagnostic testing for one physical exam per person per calendar year.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Immunizations

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Doses, recommended ages and recommended populations vary by immunization.

Covered immunizations for adults include:

- COVID-19
- Hepatitis A
- Hepatitis B
- Herpes Zoster or Recombinant Zoster (Shingles)
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Respiratory Syncytial Virus (RSV)
- Tetanus, Diphtheria, Pertussis
- Varicella

Covered immunizations for children from birth to age 18 include the following (doses, recommended ages and recommended populations vary by immunization):

- COVID-19
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Respiratory Syncytial Virus (RSV)
- Rotavirus
- Varicella

Routine Cervical Cancer Screening (Pap Smear)

Coverage is provided for one routine pap smear per calendar year, (or as Medically Necessary), as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Includes Human Papillomavirus (HPV) DNA test once every three years for women with normal cytology results who are 30 and older.

Routine GYN Exam

Coverage is provided for one gynecological exam per calendar year, (or as Medically Necessary), as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Routine Mammography

Coverage is provided for one routine mammography screening per calendar year for women age 40 and older, (or as Medically Necessary).

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Routine Prostate Cancer Screening

Coverage is provided for a prostate specific antigen test (PSA) once each calendar year, (or as Medically Necessary), as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Routine Hearing Exams

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Hearing aids, cochlear implants, and related services are not covered under the Plan.

Well Child Care

The Plan's Well Child Care Program provides coverage for children from birth to age two. Coverage includes the routine, well child, office visits and immunizations.

Coverage is provided as follows:

- If you use a Participating Provider: Covered at 100% of the Network rate.
- If you do not use a Participating Provider: Not covered.

Additional Covered Preventive Services for Adults:

Recommended age and visit limits vary by service.

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Cholesterol screening for adults of certain ages or at higher risk, limited to one per calendar year
- Colorectal Cancer screening for adults over 50 (pre-certification required)
- Type 2 Diabetes screening for adults with high blood pressure, limited to one per calendar year.
- HIV screening for all adults at higher risk, limited to one per calendar year.

Additional Covered Preventive Services for Women, Including Pregnant Women:

Recommended age and visit limits vary by service.

- BRCA testing and related counseling for women at higher risk of breast cancer (pre-certification required)
- Cervical Cancer screening for sexually active women, limited to one per calendar year.
- Osteoporosis screening for women over age 60 depending on risk factors, limited to one per calendar year.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.

Additional Covered Preventive Services for Children:

Recommended age and visit limits vary by service.

- Congenital Hypothyroidism screening for newborns
- Dyslipidemia screening for children at higher risk of lipid disorders
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children, limited to one per calendar year.

Rules When Preventive Services Are Provided as Part of an Office Visit by Billing

If a preventive item or service is billed separately from an office visit, the Plan may impose cost-sharing requirements with respect to the office visit (but not the preventive item or service).

If a preventive item or service is not billed separately from an office visit, whether cost-sharing requirements may apply to that office visit depends on the primary purpose of the office visit. If the primary purpose is to obtain the preventive item or service, the Plan will not impose cost sharing. If the primary purpose is not the delivery of the preventive item or service, the Plan may impose cost sharing for the office visits.

Medical Management requirements will still apply to preventive services.

Legal Notices

Notice Regarding the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the patient and the attending physician, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information on WHCRA benefits, the amount of coverage available to you, and copayment, deductible and maximum amounts, please refer to the *Schedule of Benefits.* You may also contact the Contract Administrator for additional information.

Notice Regarding the Newborns' and Mothers' Health Protection Act

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's and newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or Amalgamated Medical Care Management for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Regarding the Genetic Information Non-Discrimination Act ("GINA")

GINA prohibits discrimination by group health plans, such as the Fund, against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Fund.

Notice Regarding the Patient Protection Rights of the Affordable Care Act

The Fund does not require the designation of a primary care provider. However, you may wish to choose a primary care provider who participates in the network and who is available to accept you or your family members. For a list of the participating primary care providers, contact the telephone number on the back of your Identification Card or access Anthem's website at https://www.bcbs.com/find-a-doctor.

For Children, you may choose a pediatrician as the primary care provider.

You do not need prior authorization from the Fund or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card, or access Anthem's website at https://www.bcbs.com/find-a-doctor.

As noted above, the Fund does not require the selection or designation of a primary care provider. You can visit any In-Network or Out-of-Network Health Care Professional; however, payment by the Plan may be less for the use of an Out-of-Network provider.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed or have a complaint concerning the No Surprises Act, you may contact the Fund Office at 973-735-6464 or the Employee Benefit Security Administration ("EBSA") toll free number at 1-866-444-3272.

External Review Process of Certain Coverage Determinations

If your claim for benefits related to items and services covered under the No Surprises Act has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome after exhausting the Plan's internal claims and appeals process, you may be eligible for External Review of the determination if your appeal relates to whether the Fund is complying with the No Surprises Act.

Visit www.dol.gov/ebsa for more information about your rights under federal law.

How The Plan Works With Other Health Care Coverage

Coordination of Benefits

This Fund has been designed to help provide specific benefits to meet expenses of illness or injury to the extent that payment is not available from other sources. Benefits are not paid by this Fund to the extent that payment may be obtained by the Covered Participant from some other source such as another plan/fund, insurance, a legal claim, or an administrative claim. Benefits are not paid by this Fund to the extent that services or supplies may be furnished, paid for, or otherwise provided for under any law or government program.

Your Plan has a Coordination of Benefits (COB) provision that determines how payments are made if you or your dependents are covered by more than one health care coverage plan. Like most health care coverage, your Plan follows the "primary" and "secondary" rules of coverage. This means that in each case, the coverage that is considered primary pays first to the full extent of its coverage. Then, the secondary coverage pays an additional amount, up to the full extent of its coverage. Coverage is up to but never more than 100% of the actual billed charges. Benefits payable under other insurance or coverage include the benefits that would have been payable had a claim been made.

If a Covered Participant is covered under one or more other plans in addition to this Fund, this Fund will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Fund will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the Covered Participant failed to take the action required under the other plan's rules. This could occur in a case where the Covered Participant was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. It could also occur in cases where the Covered Participant failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.

Whenever payments should have been made under the Fund in accordance with this provision, but the payments have been made under any other contract, the Fund has the right to pay to those organizations making the other payments any amounts it determines to be warranted to satisfy

the intent of this provision. Amounts paid shall be deemed to be benefits paid under the Fund and the Fund shall be fully discharged from liability.

Whenever payments have been made by the Fund for benefits in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Fund shall have the right to recover the excess from among the following, as the Fund shall determine: any person to or for whom such payments were made, any insurance company, or any other organizations. The Participant, personally and on behalf of his or her Dependents, shall, upon request, execute and deliver such documents as may be required to secure the Fund's rights to recover the excess payments.

Payment If You Are Covered Under More Than One Plan

You must tell us if you or a covered family member has coverage under any other health plan.

Order of Benefit Determination

A plan that does not contain a provision coordinating its benefits with those of this Plan will have liability before this Plan.

If both plans have coordination provisions, the order of benefit payment is determined using the first of the following rules that applies:

1. The benefits of a plan which covers the patient as an employee, member, or subscriber (non-dependent) are determined before those of a plan covering the patient as a dependent except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as non-dependent. Medicare is primary to the plan covering the person as a dependent then the plan covering the person as a dependent are determined before those of the plan covering that person as a non-dependent. Refer to the "Coordination of Benefits with Medicare Coverage" for additional rules that are applicable to Medicare.
2. The benefits of the plan which covers the patient as a dependent are determined after those of a plan covering the patient as an employee, member, or subscriber (non-dependent).
3. Additional Rules for Dependent Children

   When a dependent child is covered by the plans of more than one parent and all plans have a coordination provision, the benefits of the plan of the parent whose birthday occurs first in the calendar year are determined before those of the plan of the parent whose birthday occurs later in the year. If both parents have the same birthday, the benefits of the plan that has covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

   However, where the parents are divorced or separated and both plans have coordination provisions, payment will be made as follows:
   - the benefits of the plan of the parent with custody are determined first
   - the benefits of the plan of the Spouse of the parent with custody are determined second
   - the benefits of the plan of the non-custodial parent are determined third.

- the benefits of the plan of the Spouse of the non-custodial parent are determined last.

Notwithstanding the foregoing, this Plan does not cover step children. As a result, no benefits will be paid under this Plan on behalf of a Participant's step child.

Note: If there is a court decree that states otherwise, that court decree will govern.

If a dependent child is enrolled in employer-sponsored coverage as a active employee and is married and enrolled in employer-sponsored coverage through his or her spouse's employment, the benefits of the dependent child's plan are determined first and the benefits of the spouse's plan are determined second. The benefits under the parents' plan(s) will be determined third (and fourth, if applicable), in accordance with the rules noted above, provided that an allowable expense still remains.

If a dependent child is married and is enrolled in employer-sponsored coverage through their spouse's employment, the benefits of the spouse's plan are determined first and the benefits under the parents' plan(s) will be determined second, using the rules outlined above, provided that an allowable expense still remains.

4. Coordination of Benefits with COBRA Coverage

If an individual is covered as a result of having purchased continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), and is also covered under a new or current employer's group plan (to the extent possible under the terms of the Plan and COBRA) the following shall be the order of benefit determination:

- the benefits of the plan covering the person as an employee (or as that employee's dependent) will be determined first,
- the benefits of the plan covering the person as a former employee (or as that employee's dependent) will be determined second, according to the provisions of COBRA.

Coordination of Benefits with Medicare Coverage

Medicare is the federal government's health insurance program for individuals age 65 and older. Individuals under age 65 who are disabled may also be entitled to Medicare coverage after a waiting period.

If you are working in covered employment for an employer with 20 or more employees, and you are entitled to Medicare, the Plan will provide its full health care coverage first and Medicare will pay second. If you are working in covered employment for an employer with less than 20 employees, Medicare will provide coverage first and the Plan will pay second.

If you, your covered Spouse, or dependent child becomes covered by Medicare, whether because of End Stage Renal Disease (ESRD), disability, or age, you may either retain or cancel your coverage under this Plan. If you cancel your coverage under this Plan, coverage for your Spouse and/or your dependent child(ren) will terminate, but they may be entitled to COBRA continuation coverage if there has been a COBRA qualifying event. See the "Your Rights to COBRA" section for additional information.

The decision to retain or cancel coverage under this Plan is the responsibility of the Employee. Neither the Plan nor the employee's employer will provide any consideration, incentive, or benefits to encourage cancellation of coverage under this Plan.

1. **Active Employees and Spouses Age 65 and Older**

   If a Participant is age sixty-five (65) or older, or the spouse of a Participant is age sixty-five (65) or older and is entitled to benefits under Medicare and has satisfied the Fund's eligibility rules for coverage, the following rules apply:

   The Fund will be primary for any person age 65 or older who is an Active Employee (defined as a person who qualifies as "working aged" under applicable Medicare statutes) or the spouse of an Active Employee of any age.

   A Participant may decline coverage under the Fund and elect Medicare as the primary form of coverage. If the Participant elects Medicare as the primary form of coverage, the Fund, by law, cannot pay benefits secondary to Medicare for Medicare-covered Participants. The Participant shall not be eligible under this Plan as of the date they elect Medicare as the primary coverage.

2. **Disability**

   The Fund will be primary for any active Employee, spouse of an Employee, or dependent child of an active Employee who is covered under the Plan after becoming eligible for Medicare due to disability. If the Participant elects Medicare as the primary form of coverage, the Fund, by law, cannot pay benefits secondary to Medicare for Medicare-covered Participants. The Participant shall not be eligible under this Plan as of the date they elect Medicare as the primary coverage.

3. **End Stage Renal Disease (ESRD)**

   Any active Employee, spouse of an active Employee, or dependent child of an active Employee who is covered by this Plan after becoming eligible for Medicare due to end stage renal disease (ESRD) and is subject to the waiting period before Medicare becomes effective, coverage under this Plan will be primary during the waiting period. It will also be primary during the coordination period with Medicare as follows:

This Plan pays first and Medicare pays second for 30 months starting the earlier of:

i. the month in which Medicare ESRD coverage begins; or

ii. the first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Any covered Participant who is not subject to subsections 1, 2 or 3 of this Section and who is Medicare eligible will receive benefits of this Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim benefits under Medicare.

Medicaid

If a covered individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program, (CHIP), this Plan pays first and Medicaid or the State CHIP plan pays second.

TRICARE

If a dependent is covered by both this Plan and the TRICARE program that provides healthcare services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed service only. If an eligible individual under this Plan receives services in the Military Medical Hospital or Facility on account of a military service related illness or injury, benefits are not payable by this Plan.

Veterans Affairs Facility Services

If a covered individual receives services in a United States Department of Veterans Affairs Hospital or Facility on a account of a military service related illness or injury, benefits are not payable under this Plan.

If a covered individual receives services in a United States Department of Veterans Affairs Hospital or Facility on account of any other condition that is not a military service related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and are covered benefits under the Plan.

Motor Vehicle Insurance/Personal Injury Protection (PIP)

All covered individuals shall maintain or be deemed to maintain automobile and motorcycle insurance for any vehicle they operate or own, in whole or in part, which insurance shall include personal injury protection of no less than $250,000. (This insurance is often referred to as "no-fault" insurance.) This medical Plan shall be considered secondary to your no-fault motor vehicle/PIP coverage even if you elect to reduce your premium by naming this Plan as primary.

No benefits shall be paid by this Plan for expenses or fees incurred in connection with injuries sustained in an automobile or motorcycle accident or incident unless the covered individual maintains such insurance with personal injury protection of no less than $250,000 and then only to the extent such expenses or fees exceed the above noted minimum limits of personal injury protection under the covered individual's automobile or motorcycle insurance, and/or the insurance available under any other person's automobile or motorcycle insurance who was involved in the accident or incident. No benefits shall be paid for such expenses or fees which are included in the "deductible" clause of the covered individual's automobile or motorcycle policy or coinsurance.

In the event such insurance is not available under the laws of the state wherein the covered individual resides, or if the laws of such state limit coverage to something less than $250,000, then the Plan will provide benefits in accordance with this Plan for such expenses which exceed the maximum amount of protection available in such state.

To the extent that the Plan provides benefits pursuant to this section, the Plan shall have a lien and/or right of subrogation against any recovery realized by the covered individual because of the acts of a third party and, as a condition of obtaining benefits of this Plan, the covered individual shall execute an acknowledgement of the Plan's lien against any such recovery obtained by the covered individual. All other terms and conditions of this Plan remain in full force and effect.

As in all cases, Local 99 Health and Welfare Fund reserves the right to modify benefits at any time, in accordance with applicable laws.

Coverage Provided by State or Federal Law or Government Program

If you are covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second. If health care coverage is available for any condition or treatment covered by a government program (such as through a state hospital), coverage will not be provided under this Plan.

Workers' Compensation Coverage

The Plan does not provide benefits if the expenses are covered by workers' compensation, occupational disease law, or for injuries or illnesses that arise out of your employment. Workers' compensation is a state administered program which offers coverage for health care costs and loss of earnings resulting from an occupationally related disease or accident. If the expense would be covered by Workers' Compensation but for the Participant's failure to file a claim with his or her employer, this Plan will not be responsible for paying any benefits. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, the Board of Trustees, or the Claims Administrator of their rights to recover any payments that the Plan has advanced.

Additional information about Workers' Compensation can be obtained from the Division of Workers' Compensation.

Fund's Right To Restitution

When the Fund pays for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to a Covered Participant (which, for purposes of this Section, shall also mean the Covered Participant's guardian or estate) by reason of their eligibility for benefits under the Fund, the Fund has the right in equity (or other means) to obtain full restitution of the benefits paid by the Plan from:

1. Any full or partial payment which your insurance carrier makes (or is obligated or liable to make) to you or your eligible Dependents; and
2. You or your eligible Dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your, or your Dependent's or a third party's:
    a. Automobile liability coverage;
    b. Uninsured motorist coverage;
    c. Underinsured motorist coverage;
    d. Homeowner's coverage; or
    e. Other insurance coverage.

This means that, with respect to benefits the Fund pays in connection with an injury or accident, the Fund has the right to full restitution from any payment received by you or your eligible Dependents from any third party, whether or not the payment separately allocates an amount to the restitution of expenses or types of expenses covered by the Fund or the benefits provided under the Fund. Any payment received by you, your legal counsel or your eligible Dependents from a third party is subject to a constructive Trust. Any third-party payment received by you or your eligible

Dependents must be used first to provide restitution to the Fund to the extent of the benefits paid by or payable under the Fund. The balance of any third-party payment must first be applied to reduce the amount of benefits that are paid by the Fund for benefits after the payment and second be retained by you or your eligible Dependents. The Fund does not recognize the Make Whole Doctrine. However, in the event the Trustees determine that the interests of all parties warrant a reduction in the amount of the lien, no language herein will serve to restrict the right of the Fund to do so. Furthermore, no language herein will be construed to confer the right of reduction of lien to any Fund Participant or beneficiary.

You and your eligible Dependents are responsible for all expenses incurred to obtain payment from third parties, including attorneys' fees, which amounts will not reduce the amount due to the Fund as restitution. The Fund expressly rejects the Common Fund Doctrine with respect to the payment of attorneys' fees.

The Fund is entitled to obtain restitution of any amounts owed to it either from third-party funds received by you or your eligible Dependents, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the third party. A Fund representative may commence or intervene in any proceeding or take other necessary action to protect or exercise the Fund's equitable (or other) right to restitution.

By participating in the Fund, you and your eligible Dependents acknowledge and agree to the terms of the Fund's equitable (or other) rights to full restitution. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Fund Administrator, including the signing of any documents or agreements necessary for the Fund to obtain full restitution. You or your eligible Dependents are required to:

1. Notify the Fund Administrator as soon as possible and in writing that the Fund may have an equitable (or other) right to obtain restitution of any and all benefits paid by the Fund;
2. Inform the Fund Administrator in advance of any settlement proposals advanced, or agreed to by a third party or third party's insurer;
3. Provide the Fund Administrator all information requested by the Fund Administrator regarding an action against a third party, including an insurance carrier;
4. Fully cooperate with the Fund Administrator in all respects in the Plan's enforcement of its equitable (or other) rights to restitution;
5. Not settle, without the prior written consent of the Fund Administrator, any claim that you or your eligible Dependents may have against a third party, including an insurance carrier; and
6. Take all other actions as may be necessary to protect the interests of the Fund.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Fund may deny benefits to you or your eligible Dependents or take such other action as the Fund Administrator deems appropriate. The Fund has the right to reduce future payments due to you or your eligible Dependents by the amount of the benefits paid by the Fund. This right of offset will not limit the equitable (or other) rights of the Fund to recover such moneys in any other manner.

Repayment of Medical Benefits

Benefits payable by the Fund for treatment of an illness or injury shall be limited in the following ways when the illness or injury is the result of an act or omission of another (including a legal entity) and when the participant or dependent pursues or has the right to pursue a recovery for such act or omission.

The Fund shall pay benefits for covered expenses related to such illness or injury only to the extent not paid by the third party and only after the participant or dependent (and his or her attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund. Failure by the participant or dependent to enter into such an agreement will not waive, compromise, diminish, release or otherwise prejudice any of the Fund's subrogation and/or reimbursement rights. The Fund's right of first priority shall not be reduced due to a Covered Participant's own negligence.

By accepting benefits related to such illness or injury, you agree:

- that the Fund has established a lien on any recovery received by you (or your dependent, legal representative or agent);
- to notify and consult with the Fund and the Fund Administrator (or its duly authorized designee) before starting any legal action or administrative proceeding that may relate to or involve recovery of any payments of Plan benefits;
- to notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury;
- to hold any reimbursement or recovery received by you (or your covered dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss and regardless of whether any proceeds received by you are characterized in the settlement or judgment as being paid on account of expenses for which Plan benefits were paid;
- that the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Fund's claim has first priority over all other claims and rights;
- to reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of benefits paid;
- that the Fund's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise;
- that, in the event you elect not to pursue your claims against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Fund's request, any right or cause of action to the Fund;
- not to take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement;
- to cooperate in doing what is necessary to assist the Fund in recovering the benefits paid or in pursuing any recovery, including, without limitation, keeping the Fund and the Fund Administrator (or its duly authorized designee) appraised of all material developments with respect to any relevant claims, actions or proceedings;

- to forward any recovery to the Fund within ten days of disbursement by the third party or notify the Fund as to why you are unable to do so; and
- to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund's attorneys' fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan. The Fund may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a participant's or a covered dependent's future benefit payments (regardless of whether benefits have been assigned by a participant or covered dependent to the doctor, hospital or other provider), or any other remedy available to the Fund.

The Fund may permit you to turn over less the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Fund's claim is subject to prior written approval by the Fund. The Fund shall have the right to recover from you, your dependents (and/or any other person, entity or trust in possession of such funds sought by the Fund) all benefits paid on your or your dependent's behalf by the Fund for injuries or disabilities that you or your dependents have suffered for which you or they recover money in a "third party" claim or lawsuit or settlement thereof. The Fund may seek such recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

If you fail or refuse to sign a lien acknowledgement or to comply with the terms herein, then the Plan Administrator may suspend future payments to you, or recover from the providers money paid to them, or take all the foregoing actions until the Fund is made whole. In addition, the Trustees of the Fund may bring a court action against you to enforce the terms of the Plan.

We recommend that, if you are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, this Plan shall not pay for the fees your attorney might charge.

Health Care Claims and Appeals Procedures

This section describes the procedures followed by the Local 99 Health and Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. The internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review so that Plan provisions are applied consistently with respect to you and other similarly situated Participants and Dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational). The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

General Information

Claims Administrators

The Plan Administrator has delegated responsibility for initial claim decisions to the following organizations:

Claims Administrator	Types of Claims Processed
Fund Office	Direct Vision Reimbursement
Amalgamated Employee Benefits Administrators	Medical Post-Service Claims Hospital Post-Service Claims
Amalgamated Medical Care Management	Urgent, Concurrent, and Pre-Service Medical, Hospital, and Drug Claims
Vision Screening	Vision Benefits Provider

Days Defined

For the purpose of the initial claims and appeals processes, "days" refers to calendar days, not business days.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeals process, means:

- A denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit, including a determination of and individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for purposes of the claims and appeals provisions, means a provider licensed, accredited or certified to practice where care is rendered, is rendering service within the scope of that license, is providing a service for which benefits are specifically provided by the Plan.

Definition of A Claim

A claim is a request for Plan benefits made by you or your covered Dependent (also referred to as "claimant") or your authorized representative submitted in accordance with the Fund's rules.

Types of Claims

How you file a claim for benefits depends on the type of claim. There are several categories of claims:

Pre-Service Claim - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before the health care is obtained. Services requiring prior approval are outlined in the "Medical Certification Program" section.

Urgent Care Claim - An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which, lack of immediate processing of the claim (i) could seriously jeopardize the life or health of you or your insured dependent or your or your dependent's ability to regain maximum function, or (ii) in the opinion of the treating physician with knowledge of the medical condition, would subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Concurrent Claim - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of previously approved treatment or service. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Post-Service Claim - A Post-Service Claim is a request for a benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims only involve the payment or reimbursement of the cost of the care or services already rendered. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of Post-Service claims. A claim regarding the rescission of coverage will be considered a Post-Service Claim.

Eligibility Determination – An Eligibility Determination is a decision by the Contract Administrator related solely to whether you are an eligible Employee or a Covered Participant. Should the Contract Administrator determine that you are not a Covered Participant, or that you are no longer a Covered Participant under the Fund, the Contract Administrator will provide a written notice of the eligibility determination and the reasons therefor.

Claim Elements

A claim may be filed by you, your covered dependent, an authorized representative, or by a Health Care Professional. In order to appoint an authorized representative, the patient must complete and return an "Authorization for Release of Information" form, which can be obtained from the Contract Administrator. If an authorized representative is designated, any subsequent communication will be made consistent with that authorization. If an authorized representative is designated, all subsequent notices will be provided to you through your authorized representative. The Plan will honor the designated authorized representative for one (1) year before requiring a new authorization, until the designation is revoked, or as mandated by court order. You may revoke your designated authorized representative status by submitting a completed change or authorized representative form available from and to be returned to the appropriate Claims Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

An initial claim must include the following elements in order to trigger the Plan's internal claim process:

- Be written or electronically submitted (oral communication is only acceptable for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of specific treatment, service or product for which approval or payment is requested (this must include an itemization of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is the primary payer, include a copy of the other plan's Explanation of Benefits (EOB)statement along with the submitted claim.

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits, such as a verification of whether a service/item is a covered benefit or the estimated allowed amount for a service;
- A request for prior approval where prior approval is not required by the Plan;

- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim. In addition, a request for prior approval or pre-certification of a benefit that does not require prior approval or pre-certification by the Plan or an inquiry about Plan eligibility is not a claim for benefits. Your interactions with participating providers, panel providers, pharmacists or any other health care provider under the Plan will not be treated as a claim for benefits. You must file a claim for benefits in accordance with the claims procedures listed above in order to appeal a claim under the Plan.

Additional Claim Filing Requirements for Post-Service Medical Claims, including Mental Health and Substance Use Disorders

If you use Participating Providers and provide your Blue Cross Blue Shield identification card to the provider at the time of service, you do not have to file claims. The providers will do that for you. If you do not provide your Blue Cross Blue Shield identification card to your provider, you may be responsible for the total charge. All claims should be filed electronically to the local Blue Cross Blue Shield Plan with the identification number on your Blue Cross Blue Shield identification card.. Only if your provider is Out-Of-Network AND will not submit the claim on your behalf, would a paper claim (completed HCFA 1500) be mailed to the local Blue Cross Blue Shield plan based upon the location where the services were rendered. The claim submission must include the participant name, Blue Cross Blue Shield ID number beginning with prefix LNU, group number, and patient name. Claims must be received within one year of the date the expense was incurred. Be sure to keep a copy of the claim and all receipts for your records. If you received covered services from an Out-of-Network Provider who refuses to file the claim(s) on your behalf, you may also contact the Contract Administrator for assistance.

Initial Claim Decision Timeframes

Claim Filing Deadline

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a Health Care Provider.

Health Care Claims – Decision Timeframes

Pre-Service Claim

You or your authorized representative will be notified of the initial decision on the claim, whether adverse or not, as soon as possible, but not more than fifteen (15) days from receipt by the appropriate Claims Administrator. The time for deciding the claim may be extended by an additional fifteen (15) days due to matters beyond the Claims Administrator's control; provided you are given written (or electronic, if applicable) notification before the expiration of the initial fifteen (15) day determination period.

If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after your claim is filed. The notice will describe the proper procedures for filing a Pre-Service claim. Thereafter, you must refile a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, if applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have forty-five (45) days following your receipt of the notice to provide the additional information. If you do not provide the information during the forty-five (45) day period, the claim will be denied (i.e., an adverse benefit determination). During the period of time which you are permitted to supply additional information, the normal period for making the benefit determination will be suspended. The claim decision deadline is suspended until the earlier of forty-five (45) days or the date the Claims Administrator receives your response to the request for additional information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Urgent Care Claim

In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than seventy-two (72) hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you or your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Administrator notify you and your health care professional as soon as possible, but in no event later than twenty-four (24) hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than twenty-four (24) hours after receipt of the claim. Thereafter, you will have at least forty-eight (48) hours following the receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than forty-eight (48) hours after the earlier of (i) the Claims Administrator receiving the additional information or (ii) the end of the period you had to provide the specified information.

Concurrent Claim

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated. A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service and Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as applicable) notice**.**

Post-Service Claim

Post-Service Claims must be filed within 12 months from the date the expense was incurred. Participating providers may be contractually required to submit claims to the local Blue Cross office within a shorter period of time. If the provider fails to comply with the terms of their agreement, the claim may be denied; however, in this situation, the provider would be liable.

Claims for Post-Service treatments or services will be decided no later than thirty (30) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the thirty (30) day initial determination period if the claim is denied in whole or in part.

The time for deciding the claim may extend for up to fifteen (15) days if the extension is required due to matters beyond the Claims Administrator's control; provided you are given written (or electronic, as applicable notice prior to the expiration of the initial 30-day period.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial thirty (30) day determination period. Thereafter, you will have at least forty-

five (45) days after your receipt of the notice to supply the additional information. If you do not provide the information during the forty-five (45) day period, the claim will be denied (i.e., adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim will be suspended. The claim decision deadline is suspended until the earlier of forty-five (45) days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Eligibility Determination

For questions related solely to whether you are an eligible Employee or Covered Participant, the Contract Administrator shall make a decision as soon as administratively feasible, but no later than 45 days after receipt of all information needed to resolve the eligibility issue.

Initial Determination of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be provided with a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific plan provision(s) on which the denial is based;
- Describe any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;
- Provide an explanation of the Plan's internal appeal process along with time limits and information about how to initiate an appeal;
- Contain a statement of your right to bring a civil action under section 502(a) of ERISA following an appeal;
- If the denial was based on an internal rule, guideline, protocol, or other similar criteria, a statement will be provided that such a rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criteria will be provided to you free-of-charge upon request;
- If the denial was based upon Medical Necessity, Experimental Treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

- For Urgent Care Claims, the notice will describe the expedited internal appeal process applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written (or electronically, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

If an initial claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may appeal that denial. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

Internal Appeal Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan as follows:

Appeals involving Pre-Service, Urgent Care, or Concurrent Claims may be made orally by calling Amalgamated Medical Care Management (AMCM) at 800-332-5426 or in writing to:

Amalgamated Medical Care Management
Attention: Appeals Department
1 Northeastern Blvd., Suite 100
Salem, NH 03079

Appeals for Post-Service Claims should be submitted directly to:

Amalgamated Employee Benefit Administrators
Appeals Department
333 Westchester Avenue
White Plains, NY 10604

Appeals related to an Eligibility Determination should be submitted directly to the Contract Administrator:

Local 99 Health and Welfare Fund
703 McCarter Highway
Newark, NJ 07102

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit written comments, documents, records, and other information you feel is relevant to the internal appeal determination. In the case of Urgent Claims, you can submit all necessary information by telephone, facsimile, or other available similarly expeditious method.

- You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits.
- You will have the opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits.
- Your appeal will receive a full and fair review by the Plan that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination.
- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary or fiduciaries of the plan who are neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, and/or not Medically Necessary, the fiduciary or fiduciaries will:
  - Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; and
  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Pre-Service Claims – A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within thirty (30) days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

Urgent Care Claims – This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves

a medical judgement or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

Concurrent Claims – You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the applicable Claims Administrator. A determination will be made on the internal appeal and will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Post-Service Claims – The Plan will make an appeal determination no later than the date of the Board of Trustees regularly scheduled meeting immediately following the Plan's receipt of your written appeal, unless the request for an internal appeal review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for an appeal. If special circumstances require a further extension of time for processing the appeal, a determination will be rendered no later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with written (or electronic, as applicable) notice of extension describing the special circumstances and the date the appeal determination will be made. The Plan Administrator/Board of Trustees will notify you in writing (or electronically, if applicable) of the benefit determination no later than five (5) days after the appeal determination is made.

Notification of Adverse Benefit Determination Upon Appeal

The applicable Claims Administrator or the Contract Administrator will provide you with written (or electronic, if applicable) notification of the appeal determination. In the case of an adverse benefit determination, such notice shall include:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and
- You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.

Consequences Of Failing To Appeal

1. If you fail to seek a review through the Plan's appeal procedure of any adverse benefit determination, by the Claims Administrator, Contract Administrator, or Board of Trustees, the decision shall be final and binding.
2. You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.
3. After a participant who has filed an appeal has received a written decision from the applicable Contract Administrator or Board of Trustees, the participant will have six (6) months to commence any further legal action, after which, no legal action may be commenced against the Plan and/or the Board of Trustees.
4. Any legal action related to the Plan may only be brought in the United States District Court for the District of New Jersey.
5. Failure by the participant to request an appeal of a denial within the prescribed time period will constitute a waiver of the right to review of the denial and any claim will be considered barred and no action may be brought against the Plan and/or the Board of Trustees.
6. Failure to file a lawsuit, appear and participate at a scheduled hearing or failure to take any other action with respect to the denial within six (6) months of receiving the denial will bar the claim and no action may be brought.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

Non-Assignment of Rights & Benefits

The Plan provides that your rights under the Plan, including but not limited to your rights to receive benefits, appeal Plan determinations, or obtain information, may not be validly assigned to any other party, including any medical providers.

No Participant or Beneficiary shall at any time, either during the time in which he or she is covered by the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. Under the Plan's non-assignment rule, a provider or other party does not obtain any legally enforceable rights against the Plan by virtue of having you sign a standard "Assignment of Benefits" form or similar document. Those legal rights remain solely with you.

Nevertheless, the Plan in its discretion may, as a courtesy to you, honor a written request by you to send on your behalf directly to a provider payment of benefits due to you. In this regard, the Plan may treat any assignment of benefits form executed by you as a request by you to the Plan to send payment on your behalf directly to a provider. By honoring any request by you to send payment on your behalf to a provider as a convenience, the Plan does not intend to create any legal rights in favor of the provider. The Plan makes such direct payments solely on the basis of the Plan's legal obligations owed to you as a participant. A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Any oral or written representation made regarding coverage to any person or entity is made solely in the person or entity's capacity as a representative of a Covered Person covered under the Plan inquiring on the Covered Person's behalf concerning projected levels of Plan coverage. Any such representation provides no right to a person or entity independent of the rights of the Covered Person under the terms of the Plan. It does not provide the person or entity with an independent right to recover from the Plan or its representatives under any state or federal law, including state contract and tort law. Any rights a person or entity might have against the Plan or its representatives are solely those which derive from the rights of a participant under the terms of the Plan. No references to coverage and levels of benefits are binding upon the Plan or its representatives unless they have been provided by the full Board of Trustees in accordance with the governing Plan documents. Any representation regarding coverage and benefit amounts may not be relied upon by any person or entity if it is any way contrary to the terms of governing written Plan documents. Entitlements to payment under the Plan may only be obtained through action of the Trustees administering the Plan, and these Trustee actions may only be appealed by a Covered Person covered under the Plan pursuant to the Plan's appeal procedures and by a benefits claim cause of action brought in a court of competent jurisdiction under ERISA.

Your COBRA Rights

On April 7, 1986, a Federal Law, The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title X, commonly known as COBRA), was enacted requiring that most employers sponsoring group health plans offer Employees and their Dependents the opportunity to temporarily continue their health care coverage (including medical, hospital, prescription drug, dental, and optical benefits) at group rates when coverage under the Plan would otherwise end.

If you, your Spouse, and/or your Dependent Child(ren) are covered under the Plan, you and/or your Spouse or children can continue coverage for a time if coverage ends for one of several reasons, as described below.

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct)	18 Months	18 Months	18 Months
Employee reduction in hours worked (making employee ineligible for health care coverage)	18 Months	18 Months	18 Months
Employee dies	N/A	36 Months	36 Months
Employee becomes entitled to (enrolled in) Medicare benefits	N/A	36 Months	36 Months
Employee becomes divorced or legally separated	N/A	36 Months	36 Months
Dependent Child ceases to have Dependent status	N/A	N/A	36 Months

Your COBRA rights are described in this section but may be subject to change. Coverage is provided as required by law and if the law changes, your rights will change accordingly. The Fund provides no greater COBRA rights than what COBRA requires, and nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements. For additional information about your rights and obligations under the Fund and under federal law, you should contact the Contract Administrator.

COBRA Administrator

The Contract Administrator is responsible for COBRA Administration. The administrative contact and mailing address are provided below.

Local 99 Health & Welfare Fund COBRA Department
703 McCarter Highway, Suite 101
Newark, NJ 07102
Phone: 973-735-6464
Fax: 973-735-6465

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

Providing Notice of Qualifying Events

Your employer will usually notify the Contract Administrator of your death, termination of employment, reduction in hours, or retirement and the Contract Administrator will calculate when coverage will end. However, you or your family should also notify the Contract Administrator promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification.

You and/or a family member are responsible for providing the Contract Administrator with timely notice of the following qualifying events:

1. The divorce or legal separation of the Employee from his or her Spouse.
2. A child ceasing to be covered under the Plan as a Dependent Child of the Employee.
3. The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include the Employee's death, divorce or legal separation, or a child losing Dependent status.

   In addition to these qualifying events, there are two other situations where you and/or a family member must provide the Contract Administrator with notice within the timeframe noted in this section:

4. When a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If the determination is made that an individual is disabled at any time during the first 60 days of COBRA continuation coverage, the qualified beneficiary (and each other qualified beneficiary entitled to the 18-month period of COBRA due to the same initial event) may be eligible for an 11-month extension of the 18-month maximum coverage period, for a total of 29 months of COBRA continuation coverage.
5. When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

If an Active Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if: (1) they were covered under the Fund on the day before the FMLA leave began (or became covered during the FMLA leave); or (2) they will lose Fund coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Fund during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA Qualifying Events of termination of employment and reduction of hours.

You must make sure the Contract Administrator is notified of any of the occurrences listed above. Failure to provide this notice within the format and time frames described below may prevent you and/or your Dependents from obtaining or extending COBRA continuation coverage.

Manner in Which You Must Provide Notice

Notice of any of the five situations listed above must be provided in writing to the Contract Administrator. Your letter should contain the following information: your name, which of the five events listed above you are providing notice of, the date of the event, and the date in which you and/or your beneficiary will lose coverage. In the case of divorce or legal separation, you should include a copy of the divorce decree or proof of legal separation.

When the Notice Should be Sent

You must immediately notify the Contract Administrator of:

- A change in address for you and/or your covered Dependent(s).

  You must notify the Contract Administrator within 30 days of the following events:

- You or your covered Dependent(s) become covered under another group health plan; and
- The Social Security Administration determines that you or your covered Dependent, after electing COBRA, is no longer disabled.

You must notify the Contract Administrator withing 60 days of the following events:

- Divorce or legal separation of the employee and spouse;
- A child loses dependent status under the Plan (for example, ineligibility due to age);
- The occurrence of a secondary qualifying event after a qualified beneficiary is entitled to COBRA continuation coverage; and
- A qualified beneficiary becomes disabled.

If the notice has not been received by the Contract Administrator by the end of the applicable period described above, you and/or your Spouse and/or Dependent will not be entitled to choose or extend COBRA continuation coverage.

Who May Provide a Notice

Notice may be provided by the Employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the 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 you, the Employee, your Spouse, and your child are all covered by the Plan, and you and your Spouse decide to legally separate, a single notice sent by your Spouse would satisfy this requirement.

Once you have provided notice, the Contract Administrator will send you information about COBRA continuation coverage.

How to Elect COBRA Continuation Coverage

When your employment terminates, or you do not work the required number of hours to maintain participation in the Fund's health benefits program, or when the Contract Administrator is notified on a timely basis of your death, divorce, or legal separation, or of a Dependent Child losing dependent status under the Plan, the Contract Administrator will give you and/or your Dependents notice of the date on which your coverage ends and the information and forms you need to elect COBRA continuation coverage.

Under the law, you your Spouse, and/or your Dependent Children will then have 60 days from the later of (1) the date you ordinarily would have lost coverage because of one of the events described above; or (2) the date of your notice of your right to elect COBRA continuation coverage.

If you and/or any of your Dependents do not choose COBRA Continuation Coverage withing this 60-day period, you and/or they will not have any group health coverage from this Plan after coverage initially ended.

If you notified the Contract Administrator of a qualifying event and you are not entitled to COBRA continuation coverage, the Contract Administrator will send you a written notice stating the reason you are not eligible for COBRA. The Contract Administrator will provide this notice within 14 days after its receipt of your notice of qualifying event.

Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. One or more Dependents may elect COBRA even if the Employee does not elect it. One member of the family may elect COBRA for other members of the family. COBRA continuation coverage may be elected for some of the members of the family and not others. In order to elect COBRA continuation coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event. A parent or legal guardian may elect or reject COBRA continuation coverage on behalf of Dependent Children.

Coverage Provided When COBRA Continuation Coverage is Elected

If you, your Spouse, and/or your Dependent Children choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to your current coverage under the Plan that is provided for similarly situated Employees or family members, but you must pay for it. See the sections entitled "Cost of COBRA Continuation Coverage" for information on how much COBRA will cost.

COBRA Coverage in Case of Social Security Disability Income Benefits

If you, your Spouse, and/or your Dependent Child(ren) are entitled to COBRA continuation coverage for an 18-month period, such period can be extended for the Covered Person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

1. the disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and
2. the disabled Covered Person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
3. the Plan must be notified by you or the disabled Covered Person that the Social Security determination was received:
    a. no later than 60 days after it was received; and
    b. before the 18-month COBRA continuation period ends.

This extended period of COBRA continuation coverage will end at the earlier of (1) the end of 29-months from the date of the qualifying event; (2) the date the disabled individual becomes entitled to Medicare; or (3) the last day of the month after Social Security determines that the disabled individual is no longer disabled.

Acquiring A New Dependent(s) While Covered By COBRA

If you acquire a new dependent through marriage, birth, adoption, or placement for adoption while enrolled in COBRA Continuation Coverage, that person may add the dependent to COBRA for the balance of the COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new Spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, notify the Contract Administrator as soon as possible after acquiring the new dependent, but in no event after the 60th day of the qualifying event. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA continuation coverage ceases for you, your Spouse or your Dependent Child before the end of the maximum of 18, 29, or 36-month COBRA coverage period, COBRA continuation coverage will also end for the newly added Dependent. Check with the Contract Administrator for more details on how long COBRA continuation coverage can last.

Loss of Coverage

If, while you are enrolled in COBRA continuation coverage, your Spouse, or Dependent Child loses coverage under another group health plan, you may enroll the Spouse or Dependent Child for coverage for the balance of the period of COBRA continuation coverage. The Spouse or Dependent must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the Spouse or Dependent as soon as possible after the termination of the other coverage, but in no event later than the 60th day after the loss of other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA continuation coverage.

The loss of coverage must be due to exhaustion of COBRA continuation coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Multiple Qualifying Events While Covered by COBRA

If, during an 18-month period of COBRA continuation coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, divorce, or become legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA continuation period for the affected Spouse and/or child is extended to up to 36 months from the date of loss of coverage due to the occurrence of your termination of employment or reduction of hours.

For example, assume you lost your job (the first COBRA-qualifying event), and you enroll yourself and your eligible Dependents for COBRA continuation coverage. Three months after your COBRA continuation coverage begins, you divorce and your former Spouse is no longer eligible for Plan coverage. Your former Spouse can continue COBRA continuation coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA continuation coverage is not available to anyone who became your Spouse after your loss of coverage due to the termination of employment or reduction of hours. However, this extended period of COBRA continuation coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active Member) during the 18-month period of COBRA continuation coverage.

In no case are you entitled to COBRA continuation coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in hours (unless you are entitled to an additional COBRA continuation coverage period on account of Social Security disability). As a result, if you experience a reduction of hours then have a termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the date of loss of coverage due to the occurrence of the initial qualifying event.

Termination of Employment/Reduction of Hours Following Medicare Entitlement

If you become entitled to (enrolled in) Medicare and you later have a termination of employment or reduction of hours, then your Spouse and/or your Dependent Child would be entitled to COBRA continuation coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of hours or 36 months from the date you become entitled to Medicare, whichever is longer.

Cost to You for COBRA Continuation Coverage

You, your covered Spouse, and/or your Dependent Child(ren) will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, any individual or family group containing a disabled individual whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage. Any family units that do not include a disabled person will be charged 102% of the cost of coverage.

The amount you, your covered Spouse and/or your Dependent Child(ren) must pay for your COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due starting with the date continuation coverage was elected. If this payment is not made when due, COBRA continuation coverage will not take effect. There will then be a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate. The Contract Administrator will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA continuation coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA continuation coverage. You will be notified of COBRA premium changes.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate:

1. When the COBRA period (18, 29, or 36 months) ends;
2. The date the Plan no longer provides any medical or dental coverage to any of its similarly situated Employees;
3. The first day of the time period for which you do not pay the applicable premium for your COBRA continuation coverage within the required time period;
4. The date, after the date of your COBRA election, on which you or your eligible Dependent(s) first becomes entitled to (enrolled in) Medicare (usually age 65); or
5. The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become covered under another group health plan.

The Plan will be permitted to retroactively rescind an individual's coverage only for fraud or intentional misrepresentation of material facts.

If any Covered Person becomes entitled to Medicare, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any covered Spouse or Dependent Child of that Covered Person will not be affected.

If COBRA continuation coverage is cut short as described above, the Contract Administrator will send you a written notice as soon as practicable following the determination that COBRA continuation coverage will terminate. This notice will explain why COBRA continuation coverage will be or has terminated and the date of the termination.

Other Information About COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan Members, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

Once your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Board of Trustees reserves the right to terminate COBRA continuation coverage retroactively if you are determined to be ineligible.

Alternative Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you.

What is the Health Insurance Marketplace?

The Marketplace offers an efficient way to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

When Can I Enroll in Marketplace Coverage?

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you experience another qualifying event, such as marriage or birth of a child, through something called a "special enrollment period." But be careful though – if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I Enroll in Another Group Health Plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan) if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What Factors Should I Consider When Choosing Coverage Options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA continuation coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance Payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time.

- Service Area: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

General Exclusions And Limitations

The following expenses are not covered under the hospital, medical, behavioral health and substance use disorder coverage. However, some of these expenses may be covered under your prescription drug, vision, or dental coverages. Coverage details for prescription drug, vision, and dental services (where applicable) are outlined in separate benefit booklets.

- Acupressure
- Acupuncture.
- The following specific **anesthesia** services:
  - Anesthesia and consultation services when they are given in connection with non-covered services.
  - Anesthesia when administered by the operating physician, the assistant to the operating physician, or the attending physician.
  - Local anesthesia charges billed separately by a practitioner for surgery performed on an outpatient basis.
- Autism
- Autopsy
- Behavior modification
- Behavioral Problems, Developmental Disorders, and Learning Disabilities:
  - Conditions related to behavior problems or learning disabilities except as covered under psychotherapy coverage.
  - Conditions, which the Fund determines, are due to developmental disorders including, but not limited to, mental retardation, academic skills disorders, or motor skills disorders except as may be necessary to provide newly born dependents with coverage for accidental injury or sicknessincluding the necessary care and treatment of medically diagnosed congenital defects and abnormalities.
- Blood:
  - Charges for blood donors and blood donation, except as specified in the Schedule of Benefits.
  - Prophylactic blood or bone marrow storage in the event of an accident or unforeseen surgery or transplant.
- Charges and balances due for the following:
  - Broken appointments fees
  - Charges, to the extent they exceed the Allowed Amount..
  - Copayments, Deductibles, and the individual's part of any coinsurance
  - Expenses for mailing, shipping, or handling.
  - Expenses for preparing medical reports, bills, claim forms, telephone calls and/or photocopying fees.
  - Expenses incurred after any payment maximum is or would be reached.
  - Expenses incurred before the patient's coverage began or after the patient's coverage ended.
  - Expenses incurred during a Covered Person's temporary absence from an eligible provider's grounds before discharge.

- Clinical Trials
- Clinics affiliated with a hospital, except as otherwise specified under the Plan.
- Clothing or shoes of any type, except for shoes for Participants with diabetes or peripheral vascular disease and shoes used in conjunction with leg braces.
- Complications of non-covered treatments or procedures. Cost of benefits, services, supplies, or charges where a Participant has a physical or medical complication in conjunction with, or as a result of, a procedure or service which is not covered by the Plan.
- Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the body part can be expected, unless required under WHCRA or as a result of an accidental injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. Excluded services include but are not limited to, cosmetic surgery, procedures, treatment,drugs, or biological products. For purposes of this exclusion, prior surgery is not considered an accidental injury.
- Custodial/Convalescent Care. Expense for Custodial/Convalescent Care services, regardless of where they are provided, including, without limitation, domiciliary care, residential care, adult day care, child day care, personal care, or services of a homemaker or sitter/companion service, protective and supportive care including but not limited to, educational services, rest cures, or respite care.
- Dental care or treatment, including appliances, except as otherwise stated in this booklet.
- Diversional/recreational therapy or activity.
- Durable Medical Equipment:
    - Durable medical equipment requested specifically for travel purposes, recreational or athletic activities.
    - Repair and maintenance of DME and corrective appliances. Repair and maintenance for routine servicing such as testing, cleaning, regulating and checking of equipment is not covered except as specified in the schedule of benefits. Except as specified in the schedule of benefits, repair coverage is limited to the adjustment required by wear or condition change when prescribed by a participating provider and the repairs necessary to make the equipment/appliance serviceable unless the repair cost exceeds the cost of the equipment/appliance.
    - Replacement of lost or stolen durable medical equipment items within the expected useful life of the originally purchased durable medical equipment, or for continued repair of durable medical equipment after its useful life is exhausted.
    - Supportive environmental materials and equipment such as handrails, ramps, telephones and similar service appliances and devices.
- Educational or vocational testing. Services for educational or vocational testing or training and for special education, counseling or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder or other disturbance.
- Educational Services. Expenses for educational services, supplies, or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids speech aids, etc., even if they are provided because of an injury, illness, or disability of a Covered Person.
- Employer-Provided Services. Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by an Employer. Screening tests and immunizations done at your place of work at no cost to you.
- Employment/career counseling.
- Equipment or services primarily used for altering air quality or temperature.

- Equipment primarily used for non-medical purposes.
- Expenses for which a Third Party is Responsible. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that party.
- Exercise programs and equipment.
  - Exercise programs for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational, or physical therapy covered by this Plan.
  - Expenses for membership in or visits to health clubs, exercise programs, gymnasiums, or other physical fitness facilities.
- Experimental or Investigational. Technology, treatments, procedures, drugs, biological products, or medical devices that in the Fund's judgement are experimental, investigative, obsolete, unproven, or ineffective. Also excluded is any hospitalization in connection with experimental or investigational treatments.
- Failure to provide information. Failure to provide any additional documentation or information as may be requested by Contract Administrator and/or Third Party Administrator may result in no coverage.
- Fertility enhancement treatment, including any treatment or procedures leading to or in connection with assisted fertilization such as, but not limited to, artificial insemination in vitro fertilization (IVF), and gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT).
- Food and Formula:
  - Baby food, regular shelf food, or infant formula.
  - Enteral formulas administered orally and provided due to the inability to take adequate calories by regular diet, unless the enteral formula is the sole source of nutrition and except as mandated by law.
- Foot Care/Podiatry Services: Routine foot care, except for care required to treat manifestations of systematic disease-causing circulatory problems, such as diabetes or peripheralvascular disease. Foot care excluded from coverage under this Plan includes, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); removal or reduction of warts; removal of toenails (except medically necessary surgery for ingrown toenails); treatment of corns, calluses, keratosis, flat feet, weak feet, chronic foot strain, symptomatic complaints of the feet; treatment and debridement of mycotic nails not resulting in functional impairment. Podiatry services, except for capsular or bone surgery related to bunions, hammertoes, or spurs.
- Foreign Travel. Care, treatment or supplies out of the US
- Genetic counseling
- Genetic studies, except as otherwise specified in this booklet
- Guest meals and accommodations
- Hair analysis and hair transplants.
- Hazardous Pursuit, Hobby, or Activity. Services, supplies, care and/or treatment of an injury or sickness that results from engaging in a hazardous pursuit, hobby, or activity for recreation, amateur or professional status. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the covered person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk to bodily harm, including but not limited to: hang gliding; skydiving, bungee/base jumping; parasailing; parachuting; horseback riding; white/black water rafting; SCUBA diving or cave diving at any depth; diving into shallow water; use of an all-terrain

vehicle; rock climbing; use of explosives; automobile, motorcycle, aircraft, or speedboat racing; operation of a motorized pedacycle; dirt bike racing; skiing/snowboarding; reckless operation of a vehicle or other machinery; and travel to countries with advisory warnings.

- Hearing Care. Expenses for the purchase, servicing, fitting, and/or repair of hearing aid devices, including but not limited to hearing aids and cochlear implants.
- Holistic medicine Naturopathic, or homeopathic services or supplies
- Home Delivery. Elective/Pre-Planned home delivery for childbirth
- Housekeeping services
- Hypnotherapy
- Immunizations, except as otherwise specified in this booklet.
- Implants:
  - Cochlear implants, dental implants and nanometric implants, and similar services are excluded.
  - No coverage is provided for repair, replacement, or duplicates, nor is coverage provided for Health Services related to the repair or replacement of covered implants, except due to a change in Plan Participant's medical condition.
  - No coverage is provided for the services, supplies, or charges associated with the insertion, fitting, or removal of an implanted device when such devices are not covered by the Plan.
- Inpatient Admissions:
  - Inpatient admissions primarily for diagnostic studies, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life. An inpatient admission or any part of an inpatient admission primarily for:
    - Physical Therapy, except as otherwise specified in this booklet
    - Rehabilitation Therapy, except as otherwise specified in this booklet.
  - Inpatient stays to bring about non-surgical weight reduction.
  - Room and board charges for any period of time during which the covered participant was not physically present in the room.
  - Any part of a hospital stay that is primarily custodial.
- Maintenance therapy for:
  - Physical Therapy
  - Manipulative Therapy
- Massage therapy
- Medical emergency services or supplies, when not rendered by a practitioner.
- Medically unnecessary services
- Membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs or replacement of devices, equipment or parts without charge or at a reduced charge.
- Milieu therapy
- Modification of Home or Vehicles. Expenses for construction or modification to a home, residence, or vehicle required as a result of injury, illness, or disability.
- Noncompliance. All charges in connection with treatments or medications where the patient either is in non-compliance or is discharged from a hospital or SNF against medical advice.
- Oral Surgery required as part of orthodontic treatment program, required for correction of an occlusal defect, encompassing orthoganathic or prognathic surgical procedures.
- Organ Donation: Services related to organ donation where the eligible participant serves as an organ donor to an individual who is not a Covered Person.
- Orthodontia and related services

- Outpatient Hospital or Clinics for non-emergency illness, except as otherwise stated in this booklet.
- Out of Network Hospital services, except as otherwise stated in this booklet.
- Oxygen and its administration unless otherwise stated in this booklet.
- Pastoral counseling, prayer, and religious healing, including services.
- Personal comfort and convenience items.
- Physical medicine for work hardening, vocational and prevocational assessment and treating, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities.
- Prescription and Over-the-Counter Drugs, except as indicated in this booklet. Common situations where prescription and over-the-counter drugs are excluded include, but are not limited to, the following:
    - Drugs dispensed to a covered participant while a patient in a facility, includes take-home drugs.
    - Drugs dispensed by a pharmacy or provider for the outpatient use of a Covered Person, except for allergy serums and mandated pharmacological agents use for controlling blood sugar.
    - Drugs dispensed by a home health care agency provider, with the exception of intravenous drugs administered under a treatment plan approved by the Fund.
    - Drugs, obtained from a state or local public health agency. Vitamins, dietary supplements, and diet plans.
    - Non-prescription drugs or supplies, except as may be Medically Necessary and appropriate for the treatment of certain illness or injury.
- Private duty nursing, except as otherwise specified in this booklet.
- Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable.
- Prolotherapy, use of injections to strengthen tendons and ligaments.
- Psychological testing, training, or educational services for learning disabilities, school-related issues, or for the purpose of obtaining or maintaining employment.
- Rehabilitation services, including but not limited to cognitive therapy, physical therapy, occupational therapy and speech therapy for developmental delay, school-related problems, apraxia disorders (unless caused by accident or episodic illness), stuttering, autism, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders.
- Rehabilitative therapy, including but not limited to, play, music, and recreational therapy.
- Removal of abnormal skin outgrowths for cosmetic reasons and other growths including, but not limited to, paring or chemical treatments to remove corns, calluses, warts, horrified nails and all other growths, unless it involves cutting through all layers of the skin.
- Rest or convalescent cures.
- Routine Examinations, Screenings, Wellness and Educational Services, including diagnostic testing and immunizations, except as otherwise stated in this booklet. Examples of exclusions that fall under this category are listed below.
    - Routine examination/physical, diagnostic testing, immunization, treatment and preparation of specialized reports solely for employment, school/college, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports, or those ordered by a third party.
    - Premarital or similar examinations or tests not required to diagnose or treat an illness or accidental injury.
    - Screening examinations, unless specifically provided for under the Plan.
    - Research studies

- Education or experimentation
- Mandatory consultations required by hospital regulations.
- Routine pre-operative consultations
- Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation).
- Well baby care, unless specifically stated in this booklet.

- Self-administered services such as: biofeedback, patient controlled analgesia, related diagnostic testing, self-care and self-help training.
- Services performed or provided by any of the following:
  - hospital resident, intern or other practitioner who is paid by a facility or other source, who is not permitted to charge for services covered under the Plan, whether or not the practitioner is enrolled in an education or training program. However, the hospital employed physician specialists may bill separately for their services.
  - Physician or other provider who did not directly provide or supervise medical services to the patient, even if the Physician or other provider was available to do so on a stand-by basis.
  - anyone who does not qualify as a physician.
  - a provider billing for facility charges (e.g., operating room, recovery room, use of equipment) when they are not an eligible facility.
  - a member of the Covered Person's family, unless otherwise stated in this booklet:
  - licensed pastoral counselor in the course of his normal duties as a pastor or minister;
  - social worker, except as otherwise stated in this booklet;
- Services or supplies:
  - rendered in connection with non-covered services/procedures, including but not limited to anesthesia, consultations, and diagnostics;
  - eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his rights to obtain this coverage or payment for these services;
  - for which a Covered Person is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment was not covered under the Plan, such as a practitioner treating a professional or business associate, or services at a public health fair;
  - for which the provider has not received a certificate of need or such other approvals as are required by law;
  - in connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a bonafide diagnosis has been made because of existing symptoms;
  - not specifically covered under the Plan;
  - provided by a practitioner if the practitioner bills the Covered Person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the practitioner and the provider;
  - Non-medical expenses such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a physician; for legal fees and expenses incurred in obtaining medical treatment.
  - Received by veterans and active military personnel at facilities operated by the Veteran's

Administration or by the Department of Defense, unless payment is required by law.

- provided during any part of a stay at a facility, or during Home Health Care chiefly for bed rest, rest cure, convalescence, custodial or sanatorium care, diet therapy or occupational therapy;
- related to an injury or illness that arises out of any act of war (declared or undeclared) or service in the armed forces or units auxiliary of any country;
- related to injuries or illness that arises out of police actions, riots, or insurrection;
- which are specifically limited or excluded elsewhere in this booklet;
- which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;
- which are not Medically Necessary and appropriate;
- which a covered participant is not legally obligated to pay for;
- which are not covered by Medicare and not specifically referenced in this Summary Plan Description; or
- which are rendered by the Cancer Treatment Center of America

- Sexual Dysfunction: Treatment, medicines, devices or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury.
- Sports medicine treatment plans, surgery, corrective appliances, or artificial aids primarily intended to enhance athletic functions.
- Stand by services required by a practitioner; services performed by surgical assistants not employed by the facility.
- Sterilization reversal.
- Sunglasses even if by prescription.
- Supplies, braces/supports, non-medical equipment
  - Disposable medical supplies, dressings and splints unless used for treatment of fracture reductions or dislocations;
  - Medical equipment of anexpendable nature including but not limited to incontinence pads, catheters, irrigation kits, anti-embolic stockings with a pressure gradientof less than 20 MM HG, and ace bandages.
  - Replacement braces of the leg, arm, back, neck, or artificial arms and legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
  - Braces and supports needed for athletic participation or employment.
  - Corrective Appliances that do not require prescription specifications and/or are used primarily for recreational sports. Corrective Appliances used primarily for cosmetic purposes, including but not limited to cranial prostheses and molding helmets.
  - Over the counter and common first-aid supplies such as adhesive tape, gauze, antiseptics, ACE bandages, wraps, elastic supports, finger splints, and orthotics.
  - Non-medical equipment which may be used primarily for personal hygiene or for comfort/convenience of a Covered Person rather than for a medical purpose, including but not limited to: equipment or services primarily used for altering air quality or temperature,

(e.g, air conditioners, humidifiers, dehumidifiers, purifiers), equipment primarily used for non-medical purposes, saunas, hot tubs, radios, televisions, telephones, chairlifts, elevators, modification to real or personal property (whether or not recommended by a provider), diapers, first aid kits, exercise equipment, heating pads, and similar supplies which are useful to a person in the absence of illness or injury.

- Surgery, sex hormones, and related medical and psychiatric services to change sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.
- Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to conception and pregnancy of a covered person acting as a surrogate mother.
- Telephone consultations.
- Tempormandibular Joint Syndrome (TMJ) treatment by any and all means including, but not limited to, surgery, intraoral devices, splints, physical medicine, and other therapeutic devices and interventions, except for the evaluation to diagnose TMJ.
- Therapy not included in the definition of Therapy Services.
- Transplants, except as otherwise stated in this booklet.
- Transplant services where human organs were sold rather than donated and for artificial organs.
- Transportation; travel
- Travel Contrary to Medical Advice. Expenses incurred by any Covered Person during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Person.
- Treatment of mental retardation, unless covered as a biologically-based mental illness.
- Treatment of drug abuse or alcoholism when not rendered according to a written treatment plan not approved and monitored by a licensed psychologist.
- Treatment of drug abuse or alcoholism provided by halfway houses, boot camps and wilderness programs.
- Treatment for disorders relating to learning, motor skills, communication and pervasive developmental conditions such as autism.
- The following specific vision care services:
  - Corneal surgery and other procedures to correct refractive errors.
  - Eye exercises and therapy
  - Eyeglasses, contact lenses, and all fittings, except following cataract surgery.
  - Surgical correction of a refractive error or refractive keratotomy procedures including, but not limited to, radial keratotomy, photo-refractive keratotomy, and laser-assisted in situ keratomileusis (LASIK) and its variants.
- Vocational or employment counseling
- Weight Loss. Expense for weight loss clinics or commercial weight loss programs.
- Wigs, toupees, hair transplants, hair weaving, or any drug used to eliminate baldness unless deemed Medically Necessary and appropriate.
- Work related injuries or illnesses when covered by Workers' Compensation.
- For any other service or treatment except as provided in this Summary Plan Description

Coverage Restrictions and Clarifications

- Alcohol - Services, supplies, care or treatment to a Covered Person for the Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental) condition.
- Illegal acts. Expenses incurred by any Covered Person for injuries or sickness resulting from or sustained as a result of a commission or attempted commission by the Covered Person of an Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offence, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that the criminal charges be filed, or if filed, that a conviction results, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. The exclusion does not apply if the injury or sickness results from an act of domestic violence or a medical (including both physical and mental health) condition; injuries or sickness sustained by the victim of domestic violence is covered.
- Illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law.
- Illness or injury, including conditions which are the result of disease or bodily infirmity, which are covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease law coverage, or similar law; or illnesses or injuries occurring while the individual is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit or intended for wage or profit.
- Injuries or conditions for which the costs of treatment of losses concerning such injuries or conditions are recoverable through legal action or a claim settlement from another party or insurance company, except where the injury or condition is caused by an act of domestic violence. This exclusion applies whether or not the eligible participant recovers losses from another party or insurance company.
- Services, supplies, or charges resulting from injuries or conditions arising out of motor vehicle accidents, to the extent such benefits, services, supplies, or charges are payable under any medical expense payment provision (by whatever terminology used, including such benefits, services, supplies or charges mandated by law) of any motor vehicle insurance policy. Expenses incurred for injuries caused in a motor vehicle accident where the Covered Person was operating the vehicle and the Trustees determine in their sole discretion that the Covered Person had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or was under the influence of drugs that are illegal in the jurisdiction in which the accident occurred are excluded from coverage.
- Court ordered treatment which is not Medically Necessary.
- Services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services, supplies, or charges are provided outside of any such custodial or incarcerating facility or building unless payment is required by law.
- Psychiatric evaluation or therapy and/or chemical dependency treatmentwhen related to judicial or administrative proceedings or orders to theextent permitted by law; when related to mental retardation, pervasivedevelopment disorder or autism; when employer requested; whenrequired

for school; for learning disabilities; when the Plan Participant is eligible for Social Security disability benefits for a mental or emotional disability; or for the purpose of submitting a disability application for a mental or emotional condition.

Miscellaneous

Misrepresentation and Fraud

The filing of a false or misleading application for eligibility or claim for benefits is a violation of the rules of the Plan and will result in denial of the claim, an action to recover any and all benefit payments wrongfully made and suspension of coverage under the Plan, for a period not less than one (1) year from the date the fraud is discovered. If it is determined that you have committed fraud against the Plan, the Board of Trustees may, in their sole discretion, commence a lawsuit to recover any benefits paid as a result of the fraud.

Fraud includes the failure to disclose any information regarding other group health coverage under the Plan's coordination of benefits provisions or failure to disclose information regarding no-fault automobile coverage, Workers' Compensation or third-party liability under the Fund's subrogation regulations.

In the event the Contract Administrator determines that a fraudulent application for eligibility or claim for benefits has been filed by a Covered Person, the Contract Administrator will notify the Covered Person of this determination and of their right to appeal to the Board of Trustees.

Participants who engage in fraud are subject to the suspension of coverage under the Plan for themselves and their dependents for a period determined by the Trustees (up to and including permanent suspension). The initial determination of whether the participant's conduct warrants the suspension of benefits shall be made by the Contract Administrator. If the Contract Administrator determines the conduct warrants a suspension of benefits, the Contract Administrator will determine the extent and duration of the suspension.

The Plan may also retroactively and without notice (except as required by law) terminate eligibility and offset future claim payments (with respect to a participant or dependent to recoup the amount owed as a result of the retroactive termination), if it would not be considered a rescission or would be considered a permissible rescission under the Affordable Care Act.

If you disagree with the suspension of benefits, you have a right to appeal the suspension of benefits to the Board of Trustees pursuant to the Internal Claims and Appeals Procedures discussed in the "Your Right to Appeal" section. For more information, please see the "Your Right to Appeal" section.

Discretionary Authority of the Plan Administrator and its Designees

In carrying out their respective responsibilities under the Plan, the Plan's Administrator, or its delegate/designee, other Plan fiduciaries and the insurers or administrators of each Program of the Plan have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

The nature and amount of Fund benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

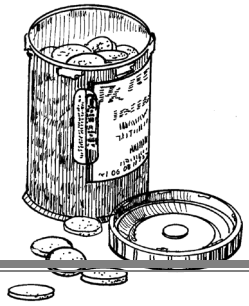
No Liability for Practice of Medicine

The Plan, Plan's administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, Plan's administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Information you or your Dependents must Furnish to the Plan

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your Dependents must furnish, within 60 days after the event, any information you or they may have that may affect eligibility for coverage under the Plan.

Prescription Drug Benefits



Prescription Drug Benefits, which are provided on a self-insured basis by the Fund, are administered by BeneCard. Such benefits are subject to the BeneCard Packet which has been provided to you. If you did not receive your BeneCard Packet at the time you received this Summary Plan Description, you should contact the Contract Administrator and request a copy of the Packet. These benefits are subject to all the rules in this Summary Plan Description.

How Your Rights Are Protected

The Fund is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). As a participant in the Local 99 Health and Welfare Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all Fund participants shall be entitled to:

A. Receive Information About Your Fund And Benefits

Examine, without charge, at the Contract Administrator's office, all documents governing the Fund, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Contract Administrator, copies of documents governing the operation of the Fund, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Contract Administrator may make a reasonable charge for the copies.

Receive a summary of the Fund's annual financial report. The Contract Administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Fund Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation coverage rights.

C. Prudent Actions By Fund Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit fund. The people who operate your fund, called "fiduciaries" of the fund, have a duty to do so prudently and in the interest of you and other fund 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.

D. Enforce Your Rights

If your claim for a welfare 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 fund documents or the latest annual report from the fund 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 Contract 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 which 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 fund'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 fund fiduciaries misuse the fund'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.

E. Assistance With Your Questions

If you have any questions about your Fund, you should contact the Contract 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 Contract Administrator, you should: 1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; 2) call the EBSA's toll-free Employee & Employer Hotline at 866-444-EBSA (3272); 3) visit the EBSA website at www.dol.gov/ebsa; or 4) write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Use and Disclosure of Protected Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, requires that health plans like the Local 99 Health and Welfare Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by your employer in its role as an employer.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is distributed to you upon enrollment in the Plan and is also available from the Fund's website at local99healthandwelfarefund.org. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

1. Use and disclosure of Protected Health Information (PHI)

   The Plan will use protected health information, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

- **"Treatment"** is the provision, coordination, or management of heath care related services. It also includes, but is not limited to, consultations and referrals between one or more of your health care providers.

- **"Payment"** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim), and establishing employee contributions for coverage;

(b) Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing collection activities and related health care data processing, and claims auditing;

(c) Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification , concurrent review and/or retrospective review.

2. Health Care Operations include, but are not limited to, the following activities:

(a) Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(c) Underwriting (the Plan does not disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502 (a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(d) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

(e) Business management and general administrative activities of the entity, including, but not limited to:

- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
- Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
- Resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

(f) Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Report's, and other documents.

3. When an Authorization Form is Needed:

Generally, the Plan will require that you sign a valid authorization form in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

4. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

5. For purposes of this section, the Board of Trustees of the Local 99 Health and Welfare Fund is the "Plan Sponsor."

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law.

(b) Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.

(c) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,

(d) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices.

(e) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(f) Make PHI available to the individual in accordance with the access requirements of HIPAA.

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.

(h) Make available the information required to provide an accounting of disclosures.

(i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services (HHS) for the purposes of determining compliance by the Plan with HIPAA, and

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

(k) If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

6. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

   (a) The Plan Administrator,

   (b) Staff designated by the Fund Administrator based on their job title and function. Fund Staff have access to individually identifiable health information, including claims information, in the Fund's computer system. Access is restricted by the use of access controls that are programmed according to the system instructions. Access is determined by the role the individual plays at the Fund.

   (c) Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, Behavioral Health Program, prescription drug program, dental claims administrator, vision claims administrator, and COBRA administrator.

7. The persons described herein may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

8. If the persons described herein do not comply with the Plan, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions and will be investigated and managed by the Plan's Privacy Officer.

9. In compliance with HIPAA Security regulations, the Plan Sponsor will:

   (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, maintains or transmits on behalf of the group health plan,

   (b) Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

   (c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

   (d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

10. **Hybrid Entity**: For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components covered by the privacy rules include only health benefits and not other plan functions or benefits.

Important Information About the Plan

Official Name of Plan

Local 99, Health & Welfare Fund

Employer Identification Number (EIN)

30-0217152

Plan Number

501

Type of Plan

Employee Welfare Benefits Plan including medical, hospital, and prescription drug.

Type of Administration of the Fund and Authority and Power of Board of Trustees

The administration of the Fund is in the hands of a Board of Trustees.

The Board of Trustees has full and exclusive discretionary authority and power to construe all Fund documents; to make all decisions concerning the interpretation, application, construction and administration of the Fund and all Fund documents; to determine all questions of eligibility for benefits, including the amount of benefits; to make final and binding decisions on all appeals; to modify, amend, discontinue or terminate benefits and/or coverage provided under this Fund; and to amend the terms of the Fund and all Fund documents.

Only the entire Board of Trustees is authorized to interpret the Fund's governing documents and exercise the discretionary authority and power described above. No officer, agent, or Employee of the Employer or the Union, nor any other person, is authorized to speak for or on behalf of the Fund, or to commit the Board of Trustees on any matter relating to the Fund, or to interpret the Fund's governing documents.

Changes In Plan Rules And Benefits

The Board of Trustees has authority to increase, decrease, modify or eliminate the benefits provided by the Fund as well as the rules under which you and your Dependents may become covered or have your coverage continued. You will be sent a description of changes that affect you. Please remember, however, that months may elapse between the time the Board makes a change and the time you are sent either a Summary of Material Modifications or a new page for your Summary Plan Description. If you want to be sure about the existence of a benefit or eligibility requirement or such, telephone the Contract Administrator.

If you do not exercise your rights under ERISA to seek review of a decision by the Board denying the benefit claim, in whole or in part, within six (6) months after the decision of the Board of Trustees, the decision of the Board shall be final and binding. No legal action may be commenced or maintained by you against the Fund.

Collective Bargaining Agreements that Relate to the Fund

This Fund is maintained pursuant to Collective Bargaining/ Participation Agreements. All Collective Bargaining or Participation Agreements that relate to the Fund are on file at the office of the Contract Administrator, and may be examined by you there during normal business hours. Upon request made in accordance with the procedure set by the Contract Administrator, you may examine the agreement(s) covering your employment at the offices of the Union. For a small charge, you may also obtain a copy of your Collective Bargaining or Participation Agreement by making a written request to the Contract Administrator.

Agent for Service of Legal Process

Legal papers and process issued by a court may be served upon the following individual at the following address:

Debra Rich, Executive Director, Local 99 Health and Welfare Fund
703 McCarter Highway, Suite 101, Newark, NJ 07102

Termination Of The Fund

In order that the Fund may carry out its obligations to maintain -- within the limits of its resources – a program dedicated to providing the benefits for all Covered Persons, the Board of Trustees has the sole power, discretion and authority to amend or terminate the Fund or merge it into another fund. Under the terms of the Fund, the Fund is to be terminated if any of the following occur:

1. The Fund's assets are, in the opinion of the Board of Trustees, inadequate to carry out the intent and purpose of the Fund or are inadequate to meet the payments due or which may become due to Covered Persons;
2. The Board of Trustees agree to terminate the Fund; or
3. Any other event which, by law, requires termination of the Fund.

If the Fund terminates, the Board of Trustees will take the following steps under the terms of the Fund:

1. Provide for the payment, out of Fund assets, of expenses (including benefits) incurred by the Fund and Covered Persons up to the date of termination, and for the payment of any expenses incidental to termination;
2. Arrange for a final audit and report of the Fund's transactions and accounts; and
3. Distribute and apply any surplus Fund assets in a manner that will inure to the exclusive benefit of the Covered Persons in accordance with the purposes of the Fund and with any requirements of law.