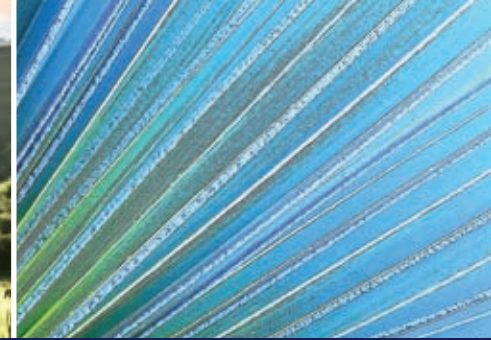


Summary Plan Description
**I.A.T.S.E. NATIONAL
HEALTH AND WELFARE FUND
PLAN C** Effective June 1, 2020





From the Board of Trustees

June 1, 2020

Dear Participant:

We are pleased to present this revised Summary Plan Description (SPD) with information about the I.A.T.S.E. National Health & Welfare Fund Plan C. It describes how you become eligible, how you can enroll dependents, who is eligible for benefits, who to contact if you have questions, and the benefits available through Plan C, including:

- **Hospital** and **medical** coverage through Empire BlueCross BlueShield;
- **Prescription drug** benefits through CVS Health;
- **Triple-S** coverage for those of you who live in Puerto Rico;
- **Dental benefits** through Delta Dental or, if you live in New York, through Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS);
- **Vision services** through Davis Vision;
- A **Medical Reimbursement Program** for certain unreimbursed medical expenses administered by the Fund Office;
- **Life insurance** through the Metropolitan Life Insurance Company (MetLife); and

The I.A.T.S.E. National Health and Welfare Fund also sponsors a Retiree Health Benefit Plan for you and your spouse if you meet the Plan's eligibility requirements.

This SPD provides a description of Plan C provisions in effect as of January 1, 2020. To help you understand important terms, we have included a glossary at the back of the book that starts on page 147.

After reading this SPD, if you have questions about the Plan or would like more information, please contact the Fund Office. A staff member will be pleased to assist you with any questions or concerns you may have. Contact information for the Plan and the Plan's benefit vendors can be found on pages 145 and 146.

Sincerely,

The Board of Trustees

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Introduction

The I.A.T.S.E. National Health & Welfare Fund (referred to in this SPD as “the Fund”) was set up to provide health care benefits to eligible participants and their enrolled dependents. It was established as the result of various collective bargaining agreements between employers and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada and its Affiliated Locals (I.A.T.S.E., or the “Union”). These collective bargaining agreements are contracts between employers and the Union that, amongst other things, require employers to contribute to the Fund on behalf of employees who are working in covered employment and covered by the Fund’s Plan C (referred to in the SPD as “the Plan” or “Plan C”).

This SPD describes the Plan provisions as of June 1, 2020.

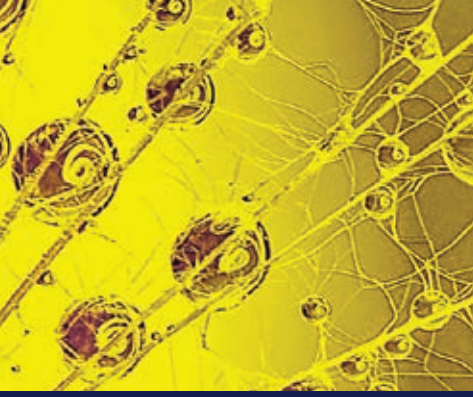
The Plan is administered by a Board of Trustees consisting of representatives appointed by the Union and the contributing employers. The Board of Trustees acts on behalf of you and your fellow Plan participants to manage all aspects of the Fund’s benefits operations and the administration of such benefits.

This SPD provides essential information about your benefits. Additional information concerning your benefits is contained in related documents, such as insurance contracts and/or certificates of coverage. This SPD (including any modifications) along with certificates of insurance for any insured benefits constitutes the Plan Document. If there is ever a conflict between any summary of benefits and the official Plan documents, the official documents will govern.

In addition, future changes to the benefits and eligibility rules described in this book will be communicated through newsletters and/or other notices from the Fund Office. Be sure to read all mail from the Fund Office carefully and keep all announcements of Plan C changes with this SPD for easy reference. You can also generally find updates on the Fund’s website by logging on to www.iatsenbf.org or through email at psc@iatsenbf.org.



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& Welfare Fund
417 Fifth Avenue
Third Floor
New York, NY
10016-2204
(212) 580-9092
1-800-456-3863**



Your Role in Managing Your Benefits

It is important that you play an active role in managing your benefits to ensure that health care coverage for you and your eligible dependents begins when you become eligible and continues uninterrupted for as long as you remain eligible. For most participants, ongoing participation in Plan C is not automatic.

- You must review the level of employer contributions received by the Fund on your behalf at least quarterly and, if a self-payment is required, submit such payment to the Fund Office on time. If you fail to take these actions, or if you miss a payment deadline, you risk a lapse or downgrade in coverage.
- If you have other employer or union sponsored group health plan coverage and want to use employer contributions for reimbursement of qualifying medical expenses (as described later in this summary), you must provide proof of your other coverage each year during Annual Open Enrollment and certify that it is compliant with the Patient Protection and Affordable Care Act (ACA). Otherwise, you will be automatically enrolled in coverage that you may not want or need.

The Fund provides resources to help you track your account and take actions on time. You will receive a quarterly statement with clearly marked deadlines. You can also get the information you need online or through an interactive voice response (IVR) telephone system. Regardless of how you choose to access the information, it's your responsibility to do so—and to take the required actions.

It is also essential that you keep Plan records (for example, your contact information, marital status and dependent information) up to date. If the Fund has incorrect information on file, your coverage may not begin when you would be otherwise eligible or, if you are already participating, it may lapse or be downgraded. Also, be sure to report changes—especially beneficiary updates—to this and any other Funds in which you participate.

This SPD describes what you need to do to make the most of your benefits. Please read it carefully and keep it in a convenient place, where you will have it for future reference. If you have any questions, please contact the Fund Office.



Benefits at a Glance

This table below provides a brief overview of the requirements for enrolling in Plan C and the benefit options available under the Plan.



Hospital and Health Benefits (through Empire BlueCross BlueShield)







PLAN C-1 & C-2	PLAN C-3	PLAN C-4
<p>Plans C-1 and C-2 both offer in-network and out-of-network benefits.</p> <p>All reimbursements of eligible out-of-network expenses are paid as a percentage of Empire BlueCross BlueShield's maximum allowed amount, which is the most Empire will pay for any service or supply.</p> <p>If an out-of-network provider charges more than the maximum allowed amount, you will be responsible for the excess, in addition to your normal coinsurance.</p> <p>In addition, applicable limits are applied to both in-network and out-of-network care combined.</p>	<p>Plan C-3 requires you to use an in-network provider.</p> <p>The doctor's office copays apply to exams and evaluations only. Other services you receive may be subject to the applicable deductible and coinsurance.</p> <p><i>If you go to an out-of-network provider, no benefits will be paid except in the case of an emergency.</i></p>	<p>Plan C-4 is a catastrophic plan with a high deductible. It requires you to use an in-network provider.</p> <p><i>If you go to an out-of-network provider, no benefits will be paid except in the case of an emergency.</i></p>


PRECERTIFICATION REQUIREMENT






Precertification is required for inpatient admissions and certain treatments and procedures to ensure the highest quality care, the right length of time in the right setting and with maximum coverage. Services or supplies that require **precertification** are noted in the first column with a telephone symbol 📞. If you fail to pre-certify, penalties may apply, or the Fund may not pay for that benefit at all. See page 49 for details on how the precertification and the Medical Management Program works and what your responsibilities are.




Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Calendar Year Deductible	\$0	\$200/ Individual \$500/ Family	\$0	\$750/ Individual \$1,875/ Family	\$1,000/ Individual \$2,500/ Family	\$3,000/ Individual \$7,500/ Family
Coinsurance	N/A	You pay 25% of the maximum allowed amount and the Plan pays 75% of the maximum allowed amount	For certain services indicated below, you pay 20% of the maximum allowed amount and the Plan pays 80%	You pay 40% of the maximum allowed amount and the Plan pays 60% of the maximum allowed amount	For certain services indicated below, you pay 20% of the maximum allowed amount and the Plan pays 80%	You pay 50% of the maximum allowed amount and the Plan pays 50% of the maximum allowed amount
Annual Out-of-Pocket Maximum	\$750/ Individual \$1,875/ Family	\$1,700/ Individual \$4,250/ Family	\$1,750/ Individual \$4,375/ Family	\$8,250/ Individual \$20,625/ Family	\$4,000/ Individual \$10,000/ Family	\$6,550/ Individual \$13,100/ Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Claim Forms to File	None	Yes	None	Yes	None	None
Annual Maximum Benefit	N/A	N/A	N/A	N/A	N/A	N/A
Doctor's Office Visits, Including Specialists	\$20/visit	Deductible and 25% coinsurance	\$25/visit, primary care; \$50/visit specialist	Deductible and 40% coinsurance	\$30/visit, primary care \$60/visit, specialist (not subject to deductible)	Deductible and 50% coinsurance; \$0 for the first three visits in a calendar year to a primary care physician not subject to the deductible
Chiropractic Visits	\$20/visit	Deductible and 25% coinsurance	\$50 for exam and evaluation; other services subject to 20% coinsurance	Deductible and 40% coinsurance	\$60 for exam and evaluation; other services subject to deductible and 20% coinsurance	Not covered
Annual Physical Exam	\$0 for one wellness exam per calendar year	See page 110 regarding \$300 annual benefit	\$0 for one wellness exam per calendar year	See page 110 regarding \$300 annual benefit	\$0 for one wellness exam per calendar year	\$0 for one wellness exam per calendar year
Acupuncture	\$20/visit	Deductible and 25% coinsurance	\$50/visit	Deductible and 40% coinsurance	\$60/visit	Deductible and 50% coinsurance


Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Allergy Care Office Visit	\$20/visit	Deductible and 25% coinsurance	\$50/visit	Deductible and 40% coinsurance	\$60/visit	Deductible and 50% coinsurance
Allergy Testing	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Allergy Treatment	\$0	Deductible and 25% coinsurance	\$0	Deductible and 40% coinsurance	\$0	Deductible and 50% coinsurance
Well Woman Care Office visits	\$0/visit	Deductible and 25% coinsurance	\$0/visit	Deductible and 40% coinsurance	\$0/visit (not subject to deductible)	\$0/visit (not subject to deductible)
Pap Smears	\$0	Deductible and 25% coinsurance	20% coinsurance if not preventive	Deductible and 40% coinsurance	Deductible and 20% coinsurance if not preventive	Deductible and 50% coinsurance if not preventive
Mammogram Based on age and medical history	\$0	Deductible and 25% coinsurance	20% coinsurance if not preventive	Deductible and 40% coinsurance	Deductible and 20% coinsurance if not preventive	Deductible and 50% coinsurance if not preventive
Well Child Care Office visits and associated lab services provided within 5 days of visit, with certain frequency limits; immunizations	\$0	Deductible and 25% coinsurance	\$0	Deductible and 40% coinsurance	\$0	\$0
Diagnostic Procedures  X-rays & other imaging; MRIs, VRAs; all lab tests	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Emergency Room 	\$35/visit (waived if admitted within 24 hours)		\$100/visit (waived if admitted within 24 hours)		\$100/visit (waived if admitted within 24 hours)	\$250/visit (waived if admitted within 24 hours)
Ambulance Local professional ground ambulance to nearest hospital	\$0	You pay the difference between the maximum allowed amount and the total charge	20% coinsurance	You pay the difference between the maximum allowed amount and the total charge	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Air Ambulance Transportation to nearest acute care hospital for emergency or inpatient admissions	\$0	You pay the difference between the maximum allowed amount and the total charge	20% coinsurance	You pay the difference between the maximum allowed amount and the total charge	Deductible and 20% coinsurance	Deductible and 50% coinsurance

Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Maternity Care  Prenatal and postnatal care in doctor's office	\$20 copay for initial visit	Deductible and 25% coinsurance	\$25 for initial exam and evaluation; other services subject to 20% coinsurance	Deductible and 40% coinsurance	\$30 for initial exam and evaluation; other services subject to deductible and 20% coinsurance	Deductible and 50% coinsurance
Maternity Lab tests, sonograms & other diagnostic procedures	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Obstetrical care in hospital 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Routine newborn nursery care in hospital 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Obstetrical care in birthing center 	\$0	Not covered	20% coinsurance	Not covered	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Hospital Services 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	\$200 per day up to 10 days, per confinement then \$0 (not subject to deductible)
Semi-private room & board; general, special and critical nursing care; intensive care; services of physicians and surgeons; anesthesia, oxygen, blood work, diagnostic x-rays and lab tests; chemotherapy and radiation therapy; drugs and dressings; pre-surgical testing; surgery (inpatient and outpatient)						
The hospital services benefit does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Outpatient hospital surgery and inpatient admissions need to be precertified.						
Chemotherapy X-Ray, Radium & Radionuclide Therapy	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Durable Medical Equipment  for example, hospital-type bed, wheelchair, sleep apnea monitor, orthotics and prosthetics	\$0	Not covered	20% coinsurance	Not covered	Deductible and 20% coinsurance	Deductible and 50% coinsurance

Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Medical Supplies Catheters, oxygen, syringes (for example)	\$0	Difference between the maximum allowed amount and the total charge (deductible and coinsurance do not apply)	20% coinsurance	Difference between the maximum allowed amount and the total charge (deductible and coinsurance do not apply)	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Nutritional Supplements Enteral formulas and modified solid food products	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Skilled Nursing Facility  Up to 60 days per calendar year	\$0	Not covered	20% coinsurance	Not covered	Deductible and 20% coinsurance	Not covered
Hospice Care Up to 365 days	\$0	Not covered	20% coinsurance	Not covered	Deductible and 20% coinsurance	Deductible and 50% coinsurance
Home Health Care Up to 200 visits per calendar year (a visit equals four hours of care) (treatment maximums are combined for in-network and out-of-network services)	\$0	25% coinsurance The deductible does not apply	20% coinsurance	40% coinsurance The deductible does not apply	20% coinsurance The deductible does not apply	50% coinsurance. The deductible does not apply.
Home Infusion Therapy	\$0	Not covered	20% coinsurance	Not covered	Deductible and 20% coinsurance	Deductible and 50% coinsurance

Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network <i>Only</i>	In-Network <i>Only</i>
Physical Therapy & Rehabilitation  Up to 30 days of in-patient service per calendar year (treatment maximums are combined for in-network and out-of-network care) Up to 50 visits combined in home, office or out-patient facility per calendar year	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	\$200/day for first 10 days, then \$0 (not subject to deductible)
	\$20/visit	Not covered	\$50/visit	Not covered	\$60 for exam and evaluation; other services subject to deductible and coinsurance	Not covered
Occupational, Speech or Vision Therapy  Up to 50 visits combined in home, office or outpatient facility per calendar year	\$20/visit	Not covered	\$50/visit	Not covered	\$60 for exam and evaluation; other services subject to deductible and coinsurance	Not covered
Cardiac Rehabilitation	\$20/outpatient visit	Deductible and 25% coinsurance	\$50/outpatient visit	Deductible and 40% coinsurance	\$60 for exam and evaluation; other services subject to deductible and 20% coinsurance	Deductible and 50% coinsurance
Mental Health Care Outpatient 	\$20/visit	Deductible and 25% coinsurance	\$25/visit	Deductible and 40% coinsurance	\$30/visit	\$0 for first three visits in a calendar year (not subject to deductible), then deductible & 50% coinsurance
Inpatient 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	\$200 per day for first 10 days, then \$0 (not subject to deductible)
Outpatient Facility 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance

Features	PLAN C-1		PLAN C-2		PLAN C-3	PLAN C-4
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network <i>Only</i>	In-Network <i>Only</i>
Alcohol or Substance Abuse Treatment						
Outpatient 	\$20/visit	Deductible and 25% coinsurance	\$25/visit	Deductible and 40% coinsurance	\$30/visit	\$0 for first three visits in a calendar year (not subject to deductible), then deductible & 50% coinsurance
Inpatient 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	\$200 per day for first 10 days, then \$0 (not subject to deductible)
Outpatient Facility 	\$0	Deductible and 25% coinsurance	20% coinsurance	Deductible and 40% coinsurance	Deductible and 20% coinsurance	Deductible and 50% coinsurance

 Precertification Required

Prescription Drug Benefits

PLANS C-1, C-2, C-3 AND C-4

CVS HEALTH STANDARD CONTROL FORMULARY

The Fund only covers drugs listed on the CVS Health “Standard Control Formulary.” A “formulary” is a list of drugs that are preferred to treat specific conditions because of the effectiveness of the drug and/or the cost of the therapy. CVS Health decides which drugs are listed on the formulary and which are excluded. If your doctor prescribes a drug that is not on the CVS Health “Standard Formulary,” an alternative drug may be covered. There is a medical appeal process if your doctor indicates that there are medical reasons that you need an excluded formulary drug. If you meet those medical conditions, you will be able to receive the excluded drug.

MANDATORY GENERIC PRICING

If you are prescribed a brand-name prescription drug that has a generic equivalent, you will be asked to switch to the generic drug when you fill the prescription at the pharmacy. If you choose to obtain the brand-name drug rather than its generic equivalent, you will be charged the generic drug copayment and the full difference in cost between the generic drug and the brand-name drug. If there is a medical reason why you must take the brand-name drug, there is a medical appeals process that would allow your doctor to provide information showing the medical necessity for the brand-name prescription.

AT AN OUT-OF-NETWORK PHARMACY

You must pay the full charge and then file a claim for reimbursement with CVS Health for the difference between the pharmacy’s charge and the applicable copayment or coinsurance.

LIMITATIONS AND EXCLUSIONS

Certain limitations and exclusions may apply to some medications. If you have any questions about a specific medication, please call CVS Health at 1-800-896-1997.

PREVENTIVE MEDICATIONS

Any prescription considered preventive care under the Affordable Care Act will be covered in full in network if required by that Act. This includes all FDA-approved generic contraceptives (or brand if the generic contraceptive is medically inappropriate). For more information as to whether a particular service will be covered in full, please contact CVS Health at 1-800-896-1997.

COPAYMENTS/COINSURANCE FOR UP TO A 30-DAY SUPPLY AT A CVS HEALTH NETWORK PHARMACY

DRUG TYPE	PLAN C-1	PLANC-2/PLAN C-3	PLAN C-4
Generic Drug	\$5	\$5	
Preferred Brand-name drug	20% coinsurance (\$25 minimum/\$40 maximum)	20% coinsurance (\$40 minimum/\$60 maximum)	Deductible and 50% coinsurance
Non-preferred Brand-name drug	40% coinsurance (\$35 minimum/\$50 maximum)	40% coinsurance (\$50 minimum/\$70 maximum)	
Preferred Specialty drug	20% coinsurance (\$25 minimum/\$150 maximum)	20% coinsurance (\$40 minimum/\$150 maximum)	Deductible and 50% coinsurance, with a maximum copayment of \$200 per script
Non-Preferred Specialty drug	40% coinsurance (\$35 minimum/\$150 maximum)	40% coinsurance (\$50 minimum/\$150 maximum)	

PARTICIPANT COPAYMENTS/COINSURANCE FOR MAINTENANCE MAIL ORDER PRESCRIPTIONS OR FOR UP TO A 90 DAY SUPPLY AT A CVS PHARMACY

DRUG TYPE	PLAN C-1	PLAN C-2/PLAN C-3	PLAN C-4
Generic drug	\$10	\$10	
Preferred Brand-name drug	20% coinsurance (\$60 minimum/\$100 maximum)	20% coinsurance (\$90 minimum/\$140 maximum)	Deductible and 50% coinsurance
Non-Preferred Brand-name drug	40% coinsurance (\$100 minimum/\$130 maximum)	40% coinsurance (\$115 minimum/\$175 maximum)	
Preferred Specialty drugs	20% coinsurance (\$60 minimum/\$300 maximum)	20% coinsurance (\$90 minimum/\$300 maximum)	Deductible and 50% coinsurance
Non-Preferred Specialty drugs	40% coinsurance (\$100 minimum/\$300 maximum)	40% coinsurance (\$115 minimum/\$300 maximum)	

Other Welfare Benefits

	PLAN C-1 AND C-2	PLAN C-3 AND C-4
Vision Care	<p>Through Davis Vision, Plans C-1 and C-2 offer one eye exam and one pair of glasses or contact lenses from the Davis Vision Collection every 24 months.</p> <p>For covered children up through age 18, an exam and lenses are provided every 12 months, while frames are available only every 24 months.</p> <p>There may be an additional charge for contact lenses or frames that are not in the approved group.</p> <hr/> <p>For out-of-network vision services, reimbursement of up to \$100 is available every 24 months (every 12 months for exams and lenses for children).</p> <p>The Plan will cover the cost of annual exams for children through age 18 up to the in-network reimbursement amount.</p>	<p>Vision care is not covered under Plan C-3 or Plan C-4. If you use a Davis Vision provider for an eye exam or to purchase glasses and/or contact lenses, you can get discounts on those services, but you must pay for them yourself.</p>
Physical Exam & Hearing Aid Benefit	<p>Physical Exam: If you do not go to a BlueCross provider for a physical exam, the Plan pays up to \$300 per calendar year for a physical examination.</p> <hr/> <p>Hearing Aid: The Plan pays up to \$1,500 in a 36-month period for a hearing aid, batteries and/or repairs</p>	<p>Not covered</p>
Participants who reside in Puerto Rico	<p>Triple-S (or other equivalent plan) is available only in Puerto Rico. If you elect this coverage, you will not be eligible for the hospital, medical and prescription drug benefits described above, but you will be entitled to the vision care, dental and life insurance benefits. Contact the plan for more information at (800) 981-1352.</p>	<p>Not applicable</p>

PLAN C-1 AND C-2

PLAN C-3 AND C-4

Dental Care

Up to \$2,000 per year per covered person paid according to a set fee schedule. The \$2,000 limit does not apply to diagnostic, preventive and basic services for children under age 19.

In-network dentists have agreed to charge a negotiated fee set by Delta Dental.

Out-of-network dentists are paid the same amount under the fee schedule as in-network dentists, but an out-of-network dentist may charge you an additional amount.

Orthodontia not covered.

Plan C-3 covers only basic preventive care in accordance with the schedule of dental benefits:

Oral exams and cleanings, up to two of each per calendar year.

X-rays, once per calendar year.

There is no dental coverage under **Plan C-4**.

Life Insurance

Pays a benefit of \$20,000 if you die while you are actively enrolled (there is no life insurance for covered dependents).

Pays a benefit of \$10,000 if you die while actively enrolled (there is no life insurance for covered dependents).



Initial Eligibility and Enrollment

The I.A.T.S.E. National Health & Welfare Fund Plan C is an individual account type plan. If an employer contributes to Plan C on your behalf, the Fund Office will set up an account in your name. You can use the amounts in your account to purchase health coverage for yourself and, if you choose, your spouse and/or dependents. You can choose single or family coverage, and you can choose from four different benefit plans. If you live in Puerto Rico, the plan has a HMO option for single or family coverage. Read on to learn about when you become eligible to elect coverage, how to enroll yourself and your dependents, what information you need to give to the Fund to enroll and where to send it, and how you can lose coverage. Remember, if you ever have any questions, you can always contact the Fund Office.

Your CAPP account

When you work in covered employment for a contributing employer, all employer contributions received on your behalf go into a CAPP (Contributions Available for Premium Payments) account in your name. The balance of your CAPP account determines:

- when you become eligible for health care coverage, and
- how much (if anything) you must contribute (self-pay) toward the cost of your coverage each coverage quarter.

You cannot contribute to your CAPP account on a pre-tax or post-tax basis. Only employer contributions based on work performed in covered employment are credited to your CAPP account. Employer contribution rates may be stated as dollars per hour, day, week or month, or as a percentage of pay.

CAPP accounts are **notional** accounts maintained for Plan participants that have no cash value: that means they are not like bank accounts from which you can withdraw money.

CAPP accounts and CAPP account balances are not vested benefits. Your CAPP account balance can be decreased if the Fund determines that employer contributions were credited to your account by mistake. The Trustees reserve the right to change CAPP account requirements and/or balances at any time.

When you first become eligible

You first become eligible for benefits when your employer makes contributions totaling \$150 plus one month's current premium cost (the "CAPP charge") for Plan C-2 single coverage. The first \$150 in employer contributions is used to pay for Fund administrative costs. This \$150 administrative fee will be charged every time you enter or re-enter the Plan. If you enroll solely in Plan C-MRP, there is an additional administrative fee (see page 26).

When you can enroll and choose your coverage level

The earliest you can enroll for Plan C coverage is when you become eligible for "optional enrollment." If you do not enroll at that time, you will have another opportunity to enroll when you become eligible for "automatic enrollment."

Optional Enrollment

You are entitled to **optional** enrollment when your CAPP account balance equals the current **monthly** CAPP charge for Plan C-2 single coverage plus the \$150 administrative fee. When you become eligible for **optional** enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

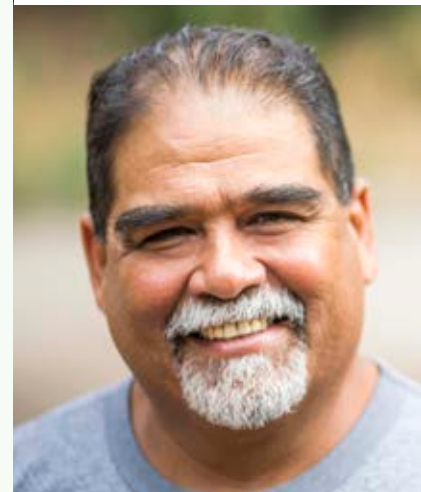
Automatic Enrollment

If you do not enroll when you first become eligible for **optional** enrollment, you cannot enroll until you become eligible for **automatic** enrollment. You are entitled to automatic enrollment when your CAPP account balance equals the current **quarterly** CAPP charge for Plan C-2 single coverage plus the \$150 administrative fee. When you become eligible for **automatic** enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

You cannot waive coverage once you become eligible for **automatic** enrollment. If you do not elect a Plan option when you become eligible for **automatic** enrollment, you will be enrolled automatically in Plan C-2 single coverage. (Participants in Puerto Rico will be enrolled automatically in single coverage under Triple-S.)

When your coverage begins

If you enroll and submit any required documentation, plus pay any applicable self-payment, by the deadline, your coverage will take effect as of the first day of the following coverage quarter. Coverage is based on calendar quarters, starting January 1, April 1, July 1 and October 1. Please see the chart on the next page to see when you will receive a CAPP statement, when your enrollment materials and self-payments (if any) are due, and when your coverage will begin.





IF CONTRIBUTIONS REQUIRED FOR ENROLLMENT ARE RECEIVED BY THE FUND OFFICE BY	THE FUND OFFICE WILL MAIL YOUR CAPP STATEMENT AND ENROLLMENT/PAYMENT FORM IN	YOUR ENROLLMENT MATERIALS AND SELF-PAYMENT (IF REQUIRED) WILL BE DUE AT THE FUND OFFICE BY	YOUR COVERAGE WILL BEGIN ON THE FIRST DAY OF THE COVERAGE QUARTER THAT BEGINS IN
October 31	mid-November	December 15	January
January 31	mid-February	March 15	April
April 30	mid-May	June 15	July
July 31	mid-August	September 15	October

When you enroll in family coverage (and pay the necessary premiums), coverage for your dependents begins on the same date that your coverage starts. This happens only if you provide all of the required documents needed to enroll your dependents by the deadline.

Enrollment Summary

The following chart summarizes the rules for initial participation in the Health & Welfare Fund Plan C:

IF EMPLOYER CONTRIBUTIONS ON YOUR BEHALF EQUAL	THEN	YOUR ENROLLMENT OPTIONS
Less than the \$150 plus the monthly charge for the Plan C-2 single coverage.	You do not yet meet the requirements to enroll.	You are not eligible to enroll.
At least \$150 plus the monthly charge for Plan C-2 single coverage.	You meet the requirements for optional enrollment.	You can enroll in Plan C-1, C-2, C-3, C-4, Triple S in Puerto Rico or C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant) or waive coverage entirely by not enrolling.
At least \$150 plus the quarterly charge for Plan C-2 single coverage.	You meet the requirements for automatic enrollment.	You can enroll in Plan C-1, C-2, C-3, C-4, Triple S in Puerto Rico or C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant). If you do not timely select a coverage option, you will be enrolled automatically in Plan C-2 single coverage (or Triple S single if you reside in Puerto Rico).

What level of benefit coverage you can elect

When you become eligible for enrollment, you will have the following choices for benefit coverage:

- **Plan C-1** (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost;
- **Plan C-2** (single or family coverage), which provides a lower level of in-network and out-of-network coverage at a lower cost than Plan C-1;
- **Plan C-3** (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2; or
- **Plan C-4** (single or family coverage), which is a high deductible plan that provides only in-network coverage at a lower cost than Plan C-1, C-2, C-3.
- **Triple S** (single or family coverage), which is a PPO and is available only to residents in Puerto Rico;
- **Plan C-MRP** (Medical Reimbursement Program) as a stand-alone option, if you provide acceptable proof that you have employer- or union-sponsored group medical coverage from employment that meets the minimum value standards of the Patient Protection and Affordable Care Act (ACA). This option is described in detail later in this SPD.

You can compare the benefits offered under each Plan by looking at the “Benefits at a Glance” at the beginning of the SPD. Each of the benefit options, Plans C-1, Triple S, C-2, C-3 and C-4, have a “CAPP charge.” The CAPP charge is the quarterly amount needed to pay for the benefits provided in that Plan option. CAPP charges are reviewed and set by the Board of Trustees every six months, on April 1 and October 1. You can find the current cost of each option on the Fund’s website, www.iatsenbf.org, or by referring to the Fund’s latest edition of its newsletter “Behind the Scenes,” or by contacting the Fund Office.

What forms you need to complete to enroll

When you become eligible for optional or automatic enrollment, the Fund Office will mail you an “Enrollment/Payment Form” that you must timely complete and return to the Fund Office Lockbox address. You must complete the form and elect which Plan option (Plan C-1, C-2, C-3, C-4, Triple S or C-MRP) you want, as well as select either single or family coverage. If your CAPP account balance is not sufficient to cover the CAPP charge for the Plan option you elected, you can self-pay for coverage. That is explained in the next section. Once you complete the Enrollment/Payment Form, and collect any required documentation you need to enroll, you can mail it to the Fund Office Lockbox at:

I.A.T.S.E. National Benefit Funds
P.O. Box 11945
Newark, NJ 07101-4945

You can also register and log in to your account online and select your coverage option by visiting the Funds’ website at www.iatsenbf.org.

How you can enroll your spouse and/or dependents

If you are eligible for coverage under Plan C, your dependents may also be eligible if you elect a family plan and pay the CAPP charge for that Plan option. When you enroll a spouse and/or dependent, you will be asked to provide proof of dependent status, such as a marriage certificate, birth or adoption certificate (as described below). Failure to timely provide documents for your dependents will delay enrollment and may result in denial of benefits. **If you are enrolling in Plan C-MRP, dependent documents are also required in order to submit claims for reimbursement on their behalf.** Your spouse and/or dependents must be enrolled in the same Plan Option as you, except that if you are enrolled in Plan C-1, C-2, C-3, C-4 or Triple S single coverage, and have **excess funds**, you may enroll your dependents in Plan C-MRP only, provided they have other minimum value group health coverage. (“**Excess funds**” are described on page 28.)

Eligible dependents include:

- the spouse to whom you are legally married
- your children, regardless of marital, financial dependency or student status, through the end of the calendar year in which they turn age 26. Children are your natural children, stepchildren, children required to be recognized under a Qualified Medical Child Support Order (QMCSO) and adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption.) Foster children, grandchildren, nieces and nephews are not eligible regardless of the guardianship.
- unmarried dependent children over age 26 who are unable to do any work to support themselves because of a physical handicap or mental illness, developmental disability or mental retardation, as supported by a Social Security disability award. The incapacity must have started before the child reached age 26, and proof that the dependent continues to be eligible for Social Security disability benefits may have to be provided periodically. Initial written proof of the child's disability must be submitted to the Fund Office within 31 days after the child's 26th birthday. Coverage under this extension ends if the dependent child is no longer considered disabled, marries or is no longer dependent on you for support/becomes able to earn a living.

The Plan requires that you submit the following documents as proof of your eligible dependents status:

- **Marriage:** To cover your spouse, you must submit a copy of the certified marriage certificate and provide your spouse's social security number.
- **Birth:** To cover a child, you must submit a copy of the certified birth certificate showing biological relationship of the child to you, the participant.

The Fund automatically covers a newborn child of any covered participant for the first 30 days of his or her life. To enroll the newborn onto your coverage, you must inform the Fund Office of the birth and submit the newborn's certified birth certificate within 60 days of the child's birth. If you cannot obtain the certified birth certificate within 60 days of birth, the Fund Office will accept hospital discharge papers, or, for a home birth, the Fund Office will accept a letter noting the date of birth from the provider who assisted the home birth. You must then submit a copy of the certified birth certificate within six months of your child's date of birth to continue coverage for that child. If you want to continue coverage for a child beyond the first 30 days, you must enroll in a family plan option.

If the newborn's parent is your unmarried covered dependent, coverage cannot be extended beyond 30 days, since the child is not an eligible dependent under the Plan.

- **Stepchild:** To cover a stepchild, you must submit a copy of his/her certified birth certificate and the marriage certificate showing that you are married to the biological parent.
- **Adoption or placement for adoption:** To cover a child you adopt, you must submit a court order signed by a judge showing that you have adopted or intend to adopt the child, along with a copy of the certified birth certificate of the adopted child.
- **Disabled Dependent Child:** To continue coverage for a disabled dependent child past his/her attainment of age 26, you must submit a copy of his/her Social Security Disability award showing that the child was determined to be disabled prior to reaching age 26. You will be required to submit this each year.

If you elect family coverage and want to enroll your spouse and/or dependents, you must provide the information when you enroll.

If you are enrolled in family coverage and wish to add a dependent after you enroll, that dependent will be covered as of the first of the month following the date the Fund receives both the request to enroll that dependent and proof of dependent status (e.g., marriage or birth certificate). However, if the new dependent is a newborn child and the Fund Office receives both a request to enroll the newborn and proof of birth (birth certificate, or if that is unavailable, hospital discharge papers or other proof from a medical provider) within 60 days of the birth, the newborn will be covered from the date of birth.

If you are enrolled in single coverage, you must enroll in family coverage to add a dependent. If you acquire a new dependent, and provided that the Fund receives the request to enroll in family coverage with proof of the new dependent (e.g., marriage or birth certificate) and any required payment for family coverage within 60 days of you acquiring such new dependent, you may enroll your dependents as of the first of the month after the Fund receives such request, proof and payment (or as of the date of birth for a newborn). If you are enrolled in single coverage, and you do not enroll your dependent (and convert to and pay for family coverage and provide the required proof of dependent status) within 60 days of acquiring a new dependent, you must wait until the next Annual Open Enrollment period to change to family coverage and enroll your dependent. Note that special circumstances (described on pages 36-37) may allow you to enroll earlier.



Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. Orders must be submitted to the Fund Office, so that the Fund Office, in consultation with Fund Counsel can determine whether the order is a QMCSO as required under federal law. You or your beneficiary can receive a copy of the Plan's procedures for handling QMCSOs at no cost by contacting the Fund Office.

The Plan provides benefits according to the requirements of a QMCSO as long as any required payment is made. The Fund Office will notify affected participants and alternate recipients if a QMCSO is received.

What happens if you elect a Plan option and don't have enough in your CAPP account to purchase that option

The Fund will reduce the balance of your CAPP account prior to each coverage quarter to pay for your coverage based on the Plan option you elect and the CAPP charge currently in effect for that Plan option. You can elect a Plan option that has a quarterly CAPP charge that exceeds the amount in your CAPP account. If you do, you must pay the difference by making a self-payment. Please note that you can only elect a higher Plan option (such as switching from Plan C-3 to Plan C-2) at the Annual Open Enrollment. Please note that the self-payment must come from you, and not your employer or a payroll house. Employer payments are credited to your CAPP account based on different timing rules.

You are responsible for ensuring that payment is received by the deadline in order for you to maintain coverage, regardless of whether or not you received a quarterly statement. If you mail a check, be sure to retain proof of mailing (for example, a receipt from UPS or a return receipt requested from the U.S. Postal Service). If you pay online, keep the confirmation number that you receive from the Fund's website. If you want to pay by providing your credit card number to the Fund Office over the telephone, a credit card authorization form must be on file with the Fund Office.

Regardless of how you make the payment, you should check your account online or by telephone to ensure that payment was received. Allow adequate time for mail and/or processing. If your account has not been credited with your payment, contact the Fund Office immediately. You will be expected to provide



proof of mailing for a check or the confirmation number for an online payment. Remember, if your payment is delayed or lost, you may lose vital coverage for yourself and your family.

If you make a self-payment, and you pay more than is needed, the excess payment will be refunded to you. It cannot be held in your account for future use.

Each quarter, the Fund Office will mail you a statement indicating your CAPP account balance, your current coverage choice, your coverage options (if applicable) and any self-payment that may be required. You can view your statement online (at www.iatsenbf.org) if you are away from home. **Please note that you are responsible to make your self-payment whether or not you actually receive your statement.** That's why the Fund provides a number of resources for you to track your balance, know what payment may be due, and understand your payment options.

How you can keep track of your CAPP account balance

Participants currently enrolled in any of Plan C's coverage options receive a quarterly CAPP statement that shows a current balance. Be sure to review your statements carefully. It is very important for you to pay attention to your CAPP account balance and any due dates for submitting documents or making payments. Managing your account is vital to ensure that health coverage continues for you and your family.

If you are a Plan C participant, you have 24/7 access to personalized information about your employment history and contributions received on your behalf - both online and by telephone. We encourage you to check your work history often so that your account is up to date when the quarterly enrollment process begins. The Fund Office does not know when and where you work, so monitoring your own account will help you get the most out of Plan C. In addition, please note that your CAPP balance may change after your statement is mailed (for example, if an MRP reimbursement claim is processed). Therefore, the best way to check your CAPP balance is online or by telephone. Remember that the Fund does not send revised statements. Please review your balance, either online or by telephone, before you make a copayment in case there has been a change in your account.

You can view your CAPP account balance and employer contribution history online. Simply follow these steps to set up a personal and confidential account:

- Log on to www.iatsenbf.org and click "Participant."
- Under "Participant Access" on the left side of the page, click "Create New Account."
- Enter the requested information. After you complete your registration, you can log on at any time by clicking "Log In" under "Participant Access" and entering your username and password.

If you do not have access to a computer with internet access, you can use our toll-free interactive voice response (IVR) phone system, which is also available 24 hours a day. Simply call (800) 456-FUND (3863). The IVR phone system uses key questions to give you confidential access to personal information about your benefits—including your current CAPP account balance.



Maintaining Eligibility and Changing Plan Options

Once you become a Plan C participant, before the start of each coverage quarter, you will receive a Plan C quarterly CAPP statement that shows:

- what Plan option you are currently enrolled in;
- your current CAPP account balance available for premium payment;
- coverage options available to you for the next coverage quarter along with any applicable self-payment due; and
- any applicable self-payment you need to make to stay in your current Plan option.

The CAPP account balance shown on your statement includes all employer contributions that were **received** in your CAPP account through the end of the applicable employer contribution period, which is two months prior to the start of the applicable coverage quarter. Any late received contributions will be available to you in a subsequent quarter. For example, employer contributions received in November and December cannot be used for coverage effective January 1. They are held in your account and can be used for coverage effective April 1. The following chart shows the timing for continuing your participation each coverage quarter.

EMPLOYER CONTRIBUTION PERIOD	MAIL DATE FOR CAPP ACCOUNT STATEMENT	DEADLINE FOR RECEIPT OF SELF-PAYMENTS	COVERAGE QUARTER
August 1–October 31	mid–November	December 15	January 1–March 31
November 1–January 31	mid–February	March 15	April 1–June 30
February 1–April 30	mid–May	June 15	July 1–September 30
May 1–July 31	mid–August	September 15	October 1–December 31

You can keep your current coverage or elect any of the other options listed on your statement. If the balance in your CAPP account is not enough to cover the Plan option that you are currently enrolled in, or if you choose a Plan option that costs more than your CAPP account balance, you will

Please be sure you monitor your CAPP account balance and material sent by the Fund carefully to make sure that you are enrolled in the best Plan option.

be required to self-pay the difference. The amount you will be required to self-pay will be included on your quarterly statement. See the section “What happens if you elect a Plan option and don’t have enough in your CAPP account to purchase that option” for more details on making self-payments.

When you can change (downgrade or upgrade) your Plan option election

You can keep the same coverage quarter after quarter provided that the balance in your CAPP account is enough to afford that coverage and you timely make any applicable self-payment(s). You can also voluntarily downgrade to a lower cost Plan option at the start of any coverage quarter. Your options for a downgrade will depend on your coverage at the time of your downgrade and will be included on the Plan C statement you receive each quarter. For example, if you have Plan C-2 family coverage, you can voluntarily downgrade to Plan C-3 family, Plan C-4 family, Plan C-2 single, Plan C-3 single, Plan C-4 single, or, if you are eligible, Plan C-MRP.

You can **upgrade** your coverage to a higher cost Plan option, such as from Plan C-3 to Plan C-2, or from single coverage to family coverage, only at the start of a new calendar year during Annual Open Enrollment—unless you experience a qualifying event, like getting married or having a baby (see page 36).

Automatic Downgrades

If the coverage you want requires a self-payment and the Fund does not receive your payment by the payment deadline, or if you are enrolled in Plan C-MRP as a standalone option and the Fund does not receive your proof of other employer or union-sponsored group medical coverage that meets the minimum value standards of the ACA during Annual Open Enrollment, your coverage will be downgraded automatically, as follows:

CURRENT ELECTION	C-1 FAMILY	C-2 FAMILY	C-3 FAMILY	C-4 FAMILY	C-1 SINGLE	C-2 SINGLE	C-3 SINGLE	C-4 SINGLE	C-MRP
Coverage Downgraded to:	C-2 Family	C-3 Family	C-4 Family	C-4 Single	C-2 Single	C-3 Single	C-4 Single	No coverage	C-2 Single
	C-3 Family	C-4 Family	C-3 Single	No coverage	C-3 Single	C-4 Single	No coverage		C-3 Single
	C-4 Family	C-2 Single	C-4 Single		C-4 Single	No coverage			C-4 Single
	C-1 Single	C-3 Single	No coverage		No coverage				No coverage
	C-2 Single	C-4 Single							
	C-3 Single	No Coverage							
	C-4 Single								
	No coverage								

As shown in the chart above, your coverage will be downgraded to the next highest level your CAPP account can afford. If your CAPP account balance is insufficient to cover the quarterly cost of Plan C-4 single coverage (the lowest-cost option), **your coverage will lapse and you will have no coverage at all under Plan C.** If this happens, in order for you to resume participation, you must meet the re-entry requirements, when eligible employer contributions in your CAPP account equal at least one month of the current cost of Plan C-3 single coverage plus the \$150 administrative fee.

When you can lose your coverage

If you have been self-paying all or part of the charge for your coverage, you lose your eligibility for continued participation in Plan C when both of the following happen:

- your CAPP account balance for the next coverage quarter is zero, and
- over the preceding 24-month period, the Fund Office has not received employer contributions on your behalf equal to at least the quarterly charge for Plan C-2 single coverage.

This is called “**Participation Termination.**”

In order to regain coverage, you must meet the rules for re-entry, when eligible employer contributions in your CAPP account equal at least the current cost of one month of Plan C-3 single coverage plus the \$150 administrative fee.

Eligibility may be terminated retroactively or you may lose benefits if you fail to notify the Fund Office in writing within 60 days of a change in family status. These events include, but are not limited to, death of a spouse or dependent, or birth or adoption of a child. You must notify the Fund Office of your divorce within 60 days of a divorce.

In addition, if you or your dependents fail to submit any requested or required information or proof to the Fund Office, make a false statement material to a claim, or furnish fraudulent or incorrect information material to a claim, benefits under the Fund may be denied, suspended or discontinued, as appropriate. The Fund has the right to recover any benefit payments made in reliance on any false or fraudulent information or proof submitted by you or your dependents, including failure to immediately advise the Fund of changes to information already provided.

If you lose coverage under Plan C, you (and/or your eligible dependents) may have an opportunity to continue coverage under the federal law known as COBRA. Under COBRA, in certain circumstances, health plans are required to offer participants the opportunity to self-pay for group coverage for a limited period of time. (See page 41 for more details on COBRA.)

When your CAPP Account is forfeited

CAPP accounts are intended for Plan participants who are working in covered employment in various segments of the entertainment industry. If there has been no activity in a CAPP account for eight (8) consecutive calendar quarters, the balance in the account will be forfeited at the end of the eighth calendar quarter to the general assets of the Health & Welfare Fund. These forfeitures help to maintain benefits and offset administrative expenses for currently active participants. We define an “inactive account” as one where (1) the participant has not elected coverage under any Plan option, (2) no medical reimbursement claims were paid, and (3) no new employer contributions were received, over eight (8) consecutive calendar quarters. For example, an account that has had no activity in 2018 or 2019 will be closed at the end of 2019, and any account balance from activity prior to 2017 will be forfeited. In order to be eligible again once funds have been forfeited, eligible employer contributions in your CAPP account must equal at least the cost of one month of Plan C-3 single plus the initial \$150 administrative fee.





Coverage under Health Fund Plan A will be considered activity for purposes of the forfeiture rule so long as you maintain a CAPP account balance equal to the cost of one quarter of Plan C-2 single coverage plus the \$150 administrative fee.

How you can combine your CAPP account with your spouse's CAPP account

If your legal spouse is also a Plan C participant, the two of you can combine your employer contributions into a single CAPP account. This combination of CAPP accounts requires written authorization from both participants. You can find a Combined CAPP Account Request Form on the Fund's website at www.iatsenbf.org.

If the Fund Office receives your completed Combined CAPP Account Request Form (signed by both parties) by the due date for participant self-payments for that quarter, your accounts will be combined at the start of the next coverage quarter. Otherwise, the combining will occur as of the first of the following coverage quarter. For example, if the Request Form is received on December 15, the combining will occur on January 1. However, if the Request Form is received on December 21, the combining will not occur until April 1.

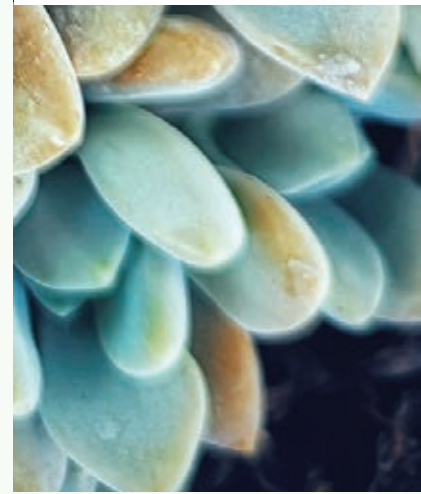
When you combine your accounts, you must designate one participant as the primary participant for the combined account and the other participant as the secondary, who will be considered a dependent of the primary participant for all purposes, including COBRA. For example, only the primary participant will be covered under the Plan's life insurance policy.

If you and your spouse have employer contributions combined into a single CAPP account, you have the option to separate them back into two individual accounts (known as "uncombining"). If you opt to uncombine, the primary participant will be changed to a single policy under the same Plan C option in which he/she is currently enrolled, if no other dependents are listed. The secondary account holder will be sent a statement and given the opportunity to elect and self-pay for any option under Plan C for which he or she is eligible. The Fund determines how much is transferred to each of your accounts based on the proportion of employer contributions received on behalf of each of you over the most recent 12 months. The uncombining will take effect as of the start of the next coverage quarter following receipt of a written request, provided that such request is received 30 days prior to the start of that coverage quarter. For example, if your request is received on March 1, the uncombining will occur on April 1. However, if it is received on March 30, the uncombining will not occur until July 1.

You should keep your personal information up to date

It is your responsibility to make sure that the Fund has accurate information for administering your Plan C participation. Otherwise, your participation may be delayed or your coverage downgraded. For example, if the Fund Office has an incorrect or no address on file for you when you become eligible to enroll, you will not receive the necessary forms. The Fund Office will send you enrollment information the first day of the following quarter upon receipt of a valid address. Retroactive enrollments are not permitted. If you have already been enrolled in coverage, you must advise the Fund if your address changes for any reason.

If your coverage is downgraded or lapses due to an incorrect address on file, you will not be permitted to make any retroactive payments to reinstate your original coverage. If coverage lapses, you will need to requalify based on Plan rules. If coverage is downgraded, you will not be permitted to upgrade until Annual Open Enrollment unless you experience a qualifying event.



You must notify the Fund Office promptly if:

- you marry,
- you have a child, you adopt a child, or you acquire a stepchild,
- you change your address or phone number (you can do this online at www.iatsenbf.org),
- you are divorced,
- a covered dependent dies,
- a child reaches the maximum age for coverage,
- a disabled child covered beyond age 26 is no longer disabled, dependent on you for support or marries, and/or
- you want to change your beneficiary. (This can be done online at www.iatsenbf.org.)



Plan C-MRP (Medical Reimbursement Program)

You can participate in Plan C-MRP as a stand-alone option or as a supplement to other coverage from Plan C if your CAPP account balance is large enough.

Plan C-MRP (Medical Reimbursement Program) is an option that allows you to be reimbursed from your CAPP account for qualifying medical expenses that you paid out of your pocket. The list of qualifying expenses is determined by the Internal Revenue Service (IRS), and is listed in the following pages. The list of qualifying expenses may change from time to time if the IRS changes the list of medical expenses that may be reimbursed on a tax-free basis.

You can participate in Plan C-MRP in one of two ways once you become eligible for coverage under Plan C:

- 1. As a stand-alone option:** If you certify and provide proof that you have other acceptable employer or union sponsored group medical coverage that meets the minimum value standard under the Patient Protection and Affordable Care Act (ACA), you can enroll in Plan C-MRP as a **stand-alone** option instead of enrolling in Plan C-1, Triple S, C-2, C-3 or C-4. Such certification and proof is required when you initially select the stand-alone Plan C-MRP option and at each Annual Open Enrollment period. Please note that you must have “group” health coverage (coverage through an employer or union) to enroll in the stand-alone MRP option. Coverage through an individual health plan or through a government program (such as Medicare, Medicaid, Tricare, or the Veterans Administration) is not acceptable other coverage for the stand-alone option. There is a \$60 per quarter administrative charge for those enrolled in the **stand-alone** Plan C-MRP. The \$60 charge is deducted from your CAPP account each quarter that you are enrolled in the **stand-alone** option.
- 2. As a supplement to other coverage from Plan C:** If you enroll in Plan C-1, Triple S, C-2, C-3 or C-4 and have **excess funds** in your CAPP account, you may participate in Plan C-MRP as a supplement to your other Plan C coverage. “Excess funds” means that the balance in your CAPP account is greater than the cost of the next two quarters of coverage in the Plan C option in which you are enrolled.

The amount available to you in any coverage quarter for qualifying expenses under Plan C-MRP is based on your CAPP account balance as of the end of the applicable employer contribution period less any deductions for the cost of coverage or reimbursed expenses. The amount does not increase until the start of the next coverage quarter.

How you enroll in Plan C-MRP as a Standalone Option

If you have other employer or union sponsored group health care coverage that meets the minimum value standard under the ACA (for example, if you are covered under your spouse's employer's plan), you may enroll in Plan C-MRP as a standalone option. By choosing this option, your CAPP account balance can be used to pay for certain medical expenses permissible by the IRS under Publication 502. **You must be enrolled in Plan C-MRP both when the expense is incurred and when you submit a claim for reimbursement.**

To enroll in Plan C-MRP as a standalone option, you must return your completed Plan C CAPP Statement and Enrollment/Payment Form, along with proof that you are enrolled in an employer or union sponsored group health plan that meets the minimum value standard under the ACA. You must submit a copy of the front and back of your insurance card from the other plan and sign the certification on the Form that your other plan is in compliance with the ACA. However, if you have not received a copy of your insurance card by the Fund's deadline, you must submit written confirmation from your other plan that you are covered under that plan and the dates your coverage is effective. Once you get your insurance card, please send a copy as soon as possible to the Fund Office to remain enrolled in Plan C-MRP. To remain enrolled in Plan C-MRP, you must submit a copy of your insurance card within 30 days of the start of the quarter.

To continue coverage in Plan C-MRP every year, you must submit a copy of your medical ID card from the other employer or union sponsored group health plan and sign the certification on the Form that your other plan is in compliance with the ACA. **You must do this each year during the Annual Open Enrollment period for as long as you remain enrolled in Plan C-MRP as a standalone option, or else you will be automatically enrolled in another Plan Option.**

Please remember that government coverage, such as Medicare, Medicaid, Tricare or coverage through the Veteran's Association, does not count as other coverage to allow you to enroll in Plan C-MRP as a standalone option. This is a federal requirement, not a rule established by the Fund.

If you are covered under Plan C-MRP and involuntarily lose your eligibility for your other health care coverage, you can transfer into Plan C-1, Triple S (if you live in Puerto Rico), C-2, C-3, or C-4. If you notify the Fund Office that you have lost other coverage within 60 days of the involuntary loss, the Fund Office will send you an enrollment form listing all the options into which you can enroll. If you timely return the form, you will be enrolled in the Plan of your choice as of the first of the month following your submission of the enrollment form and any necessary documents. If you do not timely return the enrollment form, you will be automatically enrolled single coverage under Plan C-2, C-3 or C-4, depending on your CAPP account balance, or your coverage will be terminated if your CAPP account balance is too low to afford coverage. If you do not notify the Fund Office that you have involuntarily lost coverage within 60 days of the involuntary loss, your coverage will be terminated and you must meet the initial eligibility requirements again.





You can enroll in Plan C-MRP as a supplement to your coverage under Plans C-1, C-2, C-3, C-4, A, or Triple S and use your excess funds to get reimbursed for expenses not paid by the Plan.

If you do not provide proof of other coverage by the enrollment deadline for automatic enrollment or each year during Annual Open Enrollment, you will be enrolled automatically in single coverage under Plan C-2, C-3, or C-4, depending upon which level your CAPP account balance can afford when statements are generated, and the charge for such coverage will be deducted from your CAPP account. If you are automatically enrolled in C-2, C-3, or C-4 and later submit proof of other qualifying medical coverage and later submit proof of other qualifying medical coverage, you will be enrolled in Plan C-MRP at the start of the next coverage quarter following the Fund's receipt of such proof. You will not receive a refund for the CAPP charge for Plan C-2, C-3, or C-4 if you are automatically enrolled. **If your balance is insufficient for single coverage under Plan C-4, you will not have any coverage under Plan C.** You will lapse out of coverage and will have to requalify for coverage under the Plan's eligibility rules.

Alternatively, if you are covered under Plan C-1, Triple S, C-2, C-3 or C-4 and become eligible for another employer or union sponsored group health plan coverage that meets the minimum value standards of the ACA (for example, through a spouse's employer's plan), you can submit a written election form to transfer into Plan C-MRP. The transfer will take effect the first day of the next coverage quarter after the Fund Office receives acceptable proof of your enrollment in other group health plan coverage.

How you can participate in Plan C-MRP as a supplement to Plan C-1, Triple S, C-2, C-3 or C 4, or Plan A

If you and your eligible dependents are enrolled in Plan C-1, Triple S (if you live in Puerto Rico), C-2, C-3, or C-4, you are automatically eligible to participate in Plan C-MRP as a supplement to your Plan, provided you have a sufficient balance in your CAPP account. Plan C-MRP allows you to use **excess funds** in your CAPP account to get reimbursed for medical, prescription drug, dental and vision expenses that are not paid by the Plan (subject to the administrative charge described next). **Excess funds** means any amount in excess of what is needed to pay the current and next quarter's CAPP charges for the medical coverage in which you are enrolled (Plan C-1, Triple S, C-2, C-3, or C-4).

For example, assume you are enrolled in Plan C-2 single coverage and want to submit a claim for reimbursement in January. Your excess funds would be based on your CAPP account balance as of the prior October 31 (the end of the employer contribution period for the current coverage quarter) and would equal the balance in your CAPP account that exceeds the cost of two quarters of Plan C-2 single coverage. Please keep in mind that excess funds can be used only for expenses that are incurred while you are covered under the Plan, and for those expenses that can be reimbursed according to IRS rules.

If you earn coverage under the I.A.T.S.E. National Health and Welfare Fund Plan A, and you work for an employer that contributes to Plan C on your behalf, you will have a CAPP account like any other Plan C participant, and you will automatically be enrolled in Plan C-MRP.

How you can enroll your dependents in Plan C-MRP

You may also claim reimbursement for your eligible dependents if you have properly enrolled them for coverage under Plan C-MRP. Unless you enroll your dependents in Plan C-MRP when you start coverage, your dependents will be enrolled under Plan C-MRP as of the first day of the month following the date the Fund receives your request to enroll them along with proof of their dependent status. Your dependents must be enrolled in the same Plan as you, except that if you are enrolled in Plan C-1, C-2, C-3, C-4 or Triple S single coverage, and have **excess funds**, you may enroll your dependents in Plan C-MRP only, provided that they have other minimum value group health coverage. To enroll your dependents in Plan C-MRP, you must certify that they have other employer or union sponsored health plan coverage that meets the minimum value standard of the ACA. You will not be reimbursed for your dependents' expenses incurred prior to the date they are enrolled in Plan C-MRP and they will not be enrolled until you provide the required documentation.



Where you get a Plan C-MRP claim form

You can get a claim form on the Fund's website, www.iatsenbf.org, or by requesting one through the Participant Services Center. You can easily reach the center by e-mail at psc@iatsenbf.org or by calling it Monday through Friday, 8:30 am to 5:00 pm EST, at 1-800-456-FUND (3863) or 212-580-9092 in New York. When you submit a claim, please make sure to complete all the information on the form, sign the certification, and attach all required documentation, so there is no delay in the processing of your claim.

How to submit your Plan C-MRP claim

You must sign and date your claim form and include all required documentation. You are generally required to submit the EOB (explanation of benefits) from your other group health plan, or a notice of denial from that health plan, to be reimbursed. Depending on the type of expense, you may also be required to submit a letter from the treating physician to establish the condition(s) necessitating the expense. You should furnish the Fund Office with all supporting claim documentation that you have. If more information is needed, the Fund's response will let you know what else is required. When you submit a claim for reimbursement, you must sign a certification stating that the expenses you seek reimbursement for qualify under federal tax guidelines. You will be responsible for any fees, taxes, or penalties associated with any claims reimbursed that do not comply with federal tax guidelines.

You can submit your claim for reimbursement of qualifying medical expenses by mailing it, with all required documentation, to the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, Third Floor
New York, NY 10016
Attn: Medical Reimbursement Claims

You can also submit your claims using the Fund's website, www.iatsenbf.org, by uploading your claim(s) and the appropriate required documentation, such as your other health plan's EOB (explanation of benefits), an itemized bill, proof of post-tax payment for other employer or union sponsored group health coverage, etc. You can also use the website to view the status of your claim and to view the balance of your CAPP account available for reimbursements.



Please only submit your information one time, either by mail or online. If you submit your information more than once, or by more than one method, you will slow down the Fund Office processing time.

You must file for reimbursement by the Plan C-MRP deadline

The Fund Office must receive all claims within twelve (12) months of the earliest date of service on your claim.

For example: If you have a doctor's visit on December 15, 2019 and want to submit a claim for reimbursement of the co-payment you paid for that visit, you must submit your claim (with all of the required documentation) by December 14, 2020.

Your claim will be subject to an administrative fee

There is an administrative claims processing fee subtracted from your reimbursement. Each time you submit a claim for reimbursement, an administrative charge equal to a percentage of the claim will be deducted from your CAPP account. The percentages are subject to change, but currently are as follows:

AMOUNT OF CLAIM ELIGIBLE FOR REIMBURSEMENT	ADMINISTRATIVE CHARGE
\$1– \$249	5.0%
\$250 – \$499	4.5%
\$500 – \$999	3.5%
\$1,000 – \$1,999	2.5%
\$2,000 or more	2.0%

You can only request reimbursement for qualifying medical expenses

In general, you can receive reimbursement for unreimbursed qualifying medical expenses, such as co-payments or coinsurance, as well as premiums that you pay on an after-tax basis for other group medical coverage (such as premiums you would pay to your spouse's employer provided health care plan. You can be reimbursed for all expenses that meet the definition of a "medical expense" as set forth by the Internal Revenue Service (IRS) in their Publication 502, other than premiums for individual health coverage (a Fund like ours cannot reimburse those). To see the full list of such expenses and any applicable limits and/or requirements, please go on the IRS website for Publication 502 at <https://www.irs.gov/uac/about-publication-502>.

In order to qualify for reimbursement under Plan C-MRP, a health care expense must meet all of the following requirements:

- It is incurred after the effective date of your or your dependent's coverage.
- It is on one of the lists of qualifying expenses that appear later in this section.
- It has not been and will not be reimbursed by Plan C-1, Triple S, C-2, C-3, C-4 or any other coverage.
- It is submitted with appropriate documentation, including:
 - a detailed statement or bill that includes the name, address, phone number and tax ID number of the provider; the patient's name, address, birth date and relationship to the member; and an itemization and description of the service(s) provided
 - a copy of an Explanation of Benefits (EOB) or other statement from an insurance company or other provider showing denial of reimbursement or proof that the expense is not reimbursable.
- It must be rendered by a licensed provider, in accordance with applicable law.

There are two types of qualifying expenses under Plan C-MRP: qualifying medical coverage premiums and qualifying unreimbursed medical expenses.

Qualifying Medical Coverage Premiums

To qualify for reimbursement, medical premiums must satisfy all of the following requirements:

- The group health plan must provide you or you and your dependents with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc. (Premiums that do not include you in the coverage do not qualify for reimbursement except that the Fund will reimburse your spouse's Medicare premiums even if you are not eligible for Medicare.) You can also receive reimbursement for long-term care insurance.
- The premium must have been paid after your plan coverage took effect and must be paid on a **post-tax** basis. If premiums are payable on a pre-tax basis, you will not be eligible for reimbursement.
- The premium must cover a policy that is in effect at the time reimbursement is to be paid.
- The claim must be documented with proof of payment and a description of the medical coverage provided (for example, a premium billing statement and canceled check). In the case of coverage through your spouse's employer, you will be asked to provide proof that an additional premium was paid for your coverage on a post-tax basis.

Premiums for life insurance, accidental death and dismemberment insurance, loss of income insurance or automobile insurance are not eligible for reimbursement. In no event are premiums for individual health insurance a permissible plan benefit, whether purchased in the individual insurance market or in a Health Insurance Marketplace.





The Internal Revenue Service determines the qualifying expenses that are eligible for reimbursement. You can look up IRS Publication 502 for the full rules and limitations.

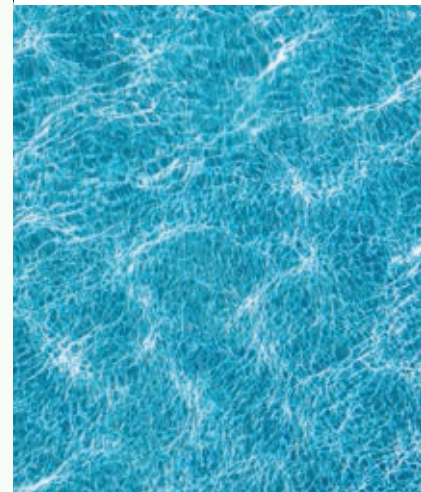
Qualifying Unreimbursed Medical Expenses

In general, the IRS defines medical expenses as the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. In addition, the services must be legal and rendered by a physician, surgeon, dentist or other medical practitioner. Medical care expenses also must be primarily to alleviate or prevent a physical or mental defect or illness; they do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

The following is a list of qualifying expenses that are eligible for reimbursement in accordance with the IRS definition (subject to the rules and limitations contained in IRS Publication 502, where applicable). The list of expenses is in alphabetical order. Please note that IRS Publication 502 also includes an extensive list of expenses that do not qualify as medical expenses eligible for reimbursement. Please contact the Fund Office if you have a question about a specific expense for reimbursement.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance/Ambulette
- Annual Physical Exam
- Artificial Limb
- Artificial Teeth
- Bandages
- Birth Control Pills
- Body Scan
- Braille Books and Magazines - If you or your eligible spouse and/or dependent is visually impaired, reimbursable expenses include the additional cost of Braille books and magazines in excess of the cost of regular printed editions.
- Breast Pumps and Supplies - Reimbursable expenses include breast pumps and supplies that assist lactation after the birth of a child.
- Breast Reconstruction Surgery, breast prostheses and surgical bras following mastectomy or other medically necessary breast surgery.
- Capital Expenses - Reimbursable expenses include special equipment that is installed in your home or any improvements or changes to your house if the main purpose is for medical care for you, your spouse, or your dependent. If the cost of the improvement increases the value of your home, the medical expense will only be the amount in excess of the additional property value. If the value of your property is not increased by the improvement, the entire cost of the special equipment or improvement is a reimbursable medical expense. There are many detailed rules included in IRS Publication 502. You should review those rules carefully and you must complete Worksheet A, the Capital Expense Worksheet, and include it with your claim form for Capital Expenses.

- Car (for persons with disabilities) - Reimbursable expenses include special hand controls and other special equipment installed in a car for the use of a person with a disability. Reimbursable expenses also include the difference in cost between a regular car and a car specifically designed to hold a wheelchair.
- Chiropractor
- Christian Science Practitioner
- Contact lenses
- Crutches
- Dental Treatment
- Diaper Service (must be for a person 3 years of age or older and required to relieve the effects of a particular disease)
- Diagnostic Devices
- Disabled Dependent Care Expenses - Some disabled dependent care expenses may qualify as reimbursable medical expenses if you are not claiming a credit for dependent care on your taxes.
- Drug Addiction treatment
- Drugs - Primarily prescription drugs/medicines only, except for insulin. Certain over the counter medication may be eligible, see IRS Publication 502.
- Eye Exam
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Guide Dog or Other Service Animal - Reimbursable expenses include the cost of buying, training and maintaining a guide dog or other service animal to assist the visually impaired or hearing disabled person, or a person with other physical disabilities.
- Health Institute - Reimbursable expenses include medical expense fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.
- Hearing Aids
- Home Care
- Hospital Services
- Insurance Premiums - As of January 1, 2016, reimbursable expenses only include those premiums paid on a **post-tax** basis. In addition to plans that cover hospital, medical, prescription drugs and dental care, you can also receive reimbursement for premiums for long-term care insurance, Medicare Part B premiums and Medicare Part D premiums. Premiums for individual health policies, including those purchased on Federal or State Health Care Exchanges, may not be reimbursed from Plan C-MRP.
- Laboratory Fees





Please see the Fund's Medical Reimbursement Program (MRP) For Plan C-MRP and Plan R-MRP Guidebook or call the Fund Office if you have questions about the program.

- Lactation Expenses
- Lead-Based Paint Removal - If you have a child who has or had lead poisoning, reimbursable expenses include the cost of removing lead-based paints from surfaces in your home.
- Legal Fees - Reimbursable expenses include legal fees you have paid that are necessary to authorize treatment for mental illness or those directly related to medical care.
- Lifetime Care - Advanced Payments - Reimbursable expenses include a lump sum fee you pay to a retirement home or institution for future medical care.
- Lodging - Reimbursable expenses include the cost of meals and lodging at a hospital or similar institution if the reason for being there is for medical care. For specific rules and limits on this, please see IRS Publication 502.
- Long Term Care - Reimbursable expenses include amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts. Reimbursement for premiums are limited based on your age, please see Publication 502 for those limits.
- Medical Conferences - Reimbursable expenses include amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse or your dependent.
- Medicines
- Menstrual care products
- Nursing Home
- Nursing Services
- Operations
- Optometrist
- Organ Donors
- Osteopath
- Oxygen - oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.
- Physical Examination
- Pregnancy Test Kit - Reimbursable expenses include the amount you paid to purchase a pregnancy test kit to determine if you are pregnant.
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special Education - Reimbursable expenses include fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments. For more information, please see IRS Publication 502.

- Special Home Costs for Intellectually and Developmentally Disabled - reimbursable expenses include the cost of keeping a person who is intellectually and developmentally disabled in a special home on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living, as long as this is not the home of a relative.
- Sterilization
- Stop Smoking Programs
- Surgery
- Telephone - Reimbursable expenses include special telephone equipment that lets a person who is deaf, hard of hearing, or has a speech disability communicate over a regular telephone.
- Therapy
- Transplants
- Transportation - Reimbursable expenses include amounts you pay for transportation primarily for, and essential to, medical care, subject to the limitations described in IRS Publication 502. You will need to provide proof of medical care obtained on the day for which you sought transportation. Receipts or proof of mileage for mileage reimbursement must be included.
- Trips - Reimbursable expenses include amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. For additional rules and limits, see Publication 502.
- Vasectomy
- Vision Correction Surgery
- Weight-Loss Program - Reimbursable expenses include amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician. For additional rules and limits, see Publication 502.
- Wheelchair
- Wig - Reimbursable expenses include the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from a disease.
- X-ray and other radiology services





Changing Your Coverage

You may be able to change your coverage level if your circumstances change. Always be sure to read all the plan rules about any changes in coverage. Remember, you can always call the Fund Office if you have any questions.

Generally, if you wish to change from single to family coverage, to upgrade from Plan C-4, C-3 or C-2, or to switch from Plan C-MRP to C-1, C-2, C-3, or C-4, you must wait until Annual Enrollment (mid-November to December 15). If you are already enrolled in family coverage, you may add another dependent as of the first day of the month following the Fund's receipt of the request to add the dependent and proof of dependent status. You may downgrade your coverage as of the start of the next coverage quarter, provided that the Fund Office receives your written request by the due date for self-payments for that quarter. However, certain circumstances outlined below allow you to change (or begin) coverage at the start of any month.

Change in Status and Special Enrollment

You may enroll yourself and/or your dependents in Plan C, or change your coverage option outside the Annual Enrollment period if any of the following situations apply:

- You get married or have a child (by birth, adoption or placement for adoption or acquire a stepchild through marriage) after you first become eligible, in which case your written request to enroll, payment of any applicable CAPP charge payments, and applicable proof (as described on page 18) must be received by the Fund Office within 60 days of the event.
- You enrolled in Plan C-MRP as a standalone option or declined to enroll your dependent(s) because you and/or your dependent(s) were covered under another medical plan, and you (or your dependent(s)) involuntarily lose that coverage. Involuntary loss of coverage means you or your dependent(s) lose coverage under a health plan for any of the following reasons:
 - termination of employment
 - reduction in hours worked
 - your spouse dies
 - you and your spouse divorce
 - your dependent loses dependent status
 - you move out of an HMO service area, your coverage terminates and no other group coverage is available
 - you or your dependent's plan stops offering coverage to a group of similarly situated individuals

- you or your dependent incurs a claim that would meet or exceed a lifetime limit on all benefits
- you or your dependent’s employer stops contributing toward coverage
- the other coverage was COBRA continuation and you or your dependent reaches the maximum length of time for COBRA continuation
- the other plan terminates.

Loss of coverage does not include failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim) or a voluntary termination of coverage by you or your dependent. Your written request to enroll and proof of loss of coverage must be received by the Fund Office within 60 days of the loss. If you were enrolled in Plan C-MRP and have lost other coverage, you must enroll in Plan C-1, C-2, C-3, or C-4 or you will be enrolled automatically in Plan C-2 single coverage. If the funds in your CAPP account are not sufficient for Plan C-2 or C-3 single coverage, you will be automatically downgraded to Plan C-3 or C-4 single coverage, if the balance in your account can afford that option. If the funds in your account are not sufficient for Plan C-4 single coverage, your coverage will lapse, and you will not be able to reenroll until the balance in your CAPP account equals the monthly charge for Plan C-3 single coverage plus the \$150 administrative fee.

- You are required to provide dependent coverage through a Qualified Medical Child Support Order (QMCSO).
- You and your dependents have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. The Fund must receive your written request to enroll and proof of such loss within 60 days after the Medicaid or CHIP coverage ends.
- You (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, the Fund must receive your written request to enroll and proof of eligibility within 60 days after you (or your dependents) are determined to be eligible for such assistance.

Provided the applicable deadline is met, changes will be permitted as of the first day of the month following the Fund Office’s receipt of the written request, applicable proof of change in family status or special enrollment situation, and any required payment, as long as the change is consistent with the event. Eligibility may be terminated retroactively, or you may lose benefits if you fail to notify the Fund Office in writing of a change in family status or special enrollment event within the applicable time period described above.

To request special enrollment or obtain more information, please contact the Fund Office.



You may be eligible to change or begin your participation in Plan C if you have a change in family status or qualify for a special enrollment.



When Coverage Ends

Health care coverage for you under Plan C will terminate if:

- you fail to maintain your coverage—that is, you do not pay the required self-pay portion of the charge for the coverage you elect for the applicable coverage quarter and your CAPP account balance is less than the charge for one quarter of Plan C-4 single coverage, or
- your CAPP account balance is zero and you have not had employer contributions equal to the quarterly charge for Plan C-2 single coverage made over a 24-month period (see page 23), or
- the Plan terminates.

Health care coverage for your dependents will terminate if:

- your coverage ends
- they no longer meet the definition of “dependent”
- the Plan cancels Plan C coverage for all dependents
- your coverage changes from family to single, or
- the Plan terminates.

When your coverage under the Plan would otherwise end, you may be able to continue coverage by electing COBRA coverage (see page 41). The Plan also has rules for limited extensions of coverage in special situations, which are described next.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period:

- due to the birth, adoption or placement of a child with you for adoption
- to provide care for a spouse, child or parent who has a serious health condition, or
- for your own serious health condition, which prevents you from performing one or more essential functions of your job.

You may be entitled to up to 26 weeks during a 12-month period to take care of a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from serious illness or injuries as a result of his or her service.

You are generally eligible for a leave under the FMLA if you:

- have worked for a contributing employer for at least 12 months
- have worked at least 1,250 hours over the previous 12 months, and
- work at a location where at least 50 employees are employed by the employer within 75 miles of the place of employment.

If you take an FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf. The Fund will accept such contributions and you will be credited with such contributions in accordance with the rules of the Plan.

If you do not return to employment following an FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave.

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA (see page 44).

Call your employer if you have questions regarding your eligibility for an FMLA leave. The Fund will not make any determinations as to whether or not you are eligible for FMLA leave.

Military Leave

If you enter military service, you will be provided continuation and reinstatement rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA protects employees who leave for and return from active duty in the uniformed services (including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces and the commissioned corps of the Public Health Service). If you are on active duty for 31 days or less, you (and eligible dependents covered under Plan C when your leave began) will continue to receive the health care coverage that you would otherwise have received under this Plan.

- If you are on active duty for more than 31 days, you can continue coverage for yourself (and eligible dependents covered under Plan C when your leave began) for up to 24 months by paying 102% of the cost of coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described on page 44).

In addition, you and your dependents may be eligible for health care coverage under TRICARE (the Department of Defense's health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE.

If you are called to active duty, you must notify the Fund Office in writing as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Plan on the day your leave started. The cost of coverage, election periods, and grace periods are the same as COBRA Continuation Coverage. However, unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.



You (and any eligible dependents covered under the Plan on the day the leave started) may be eligible simultaneously for coverage under USERRA, COBRA and TRICARE. You should consider each choice carefully. You can supplement TRICARE with USERRA or COBRA coverage, but you cannot have USERRA and COBRA coverage at the same time

When you are discharged (not less than honorably) from the uniformed services, your full eligibility will be reinstated on the day you return to work with an employer, provided that you return to employment within:

- 90 days from the date of discharge, if the period of service was more than 180 days, or
- 14 days from the date of discharge, if the period of service was at least 31 days but less than 180 days, or
- on the next regularly scheduled working day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If your CAPP account is not sufficient to cover the cost of your coverage when you return to work, you will be required to self-pay the difference in order to have immediate coverage.

If you are convalescing from injuries received during service or training, you may have up to two years from the date you completed your service to return to employment.

Contact your employer if you have questions regarding your eligibility for a leave. Contact the Fund Office if you have any questions regarding Fund benefits during a leave.

If a Participant Dies

If a participant enrolled in Plan C-MRP dies, his or her covered spouse and dependent children may use any balance remaining in the CAPP account for the deceased participant's final medical expenses as well as for reimbursement of medical expenses of any dependents enrolled in Plan C-MRP before the participant's death.

If the participant was enrolled for single coverage in Plan C-1, C-2, C-3, or C-4 and had excess funds at the time of death, those funds will remain available for reimbursement of the participant's unreimbursed medical expenses. If a participant was enrolled in single coverage but had enrolled dependents for medical reimbursement benefits, such enrolled dependents may continue to submit claims for reimbursement until the "excess funds" as of the participant's death are depleted.

If the participant was enrolled for family coverage in Plan C-1, C-2, C-3, or C-4 at the time of death, any dependents enrolled as of the participant's death may continue in coverage until the participant's CAPP account balance is zero. When the balance is less than the cost of the full quarter of coverage, the dependents may self-pay for a final quarter of coverage. Once the participant's account balance is zero, any dependents enrolled as of the participant's death may be able to elect to continue coverage only by electing COBRA coverage (see below).

Rescission of Coverage

The Fund reserves the right to terminate your and your dependents' group health coverage prospectively without notice for cause (as determined by the Board of Trustees), or if you or your dependent are otherwise determined to be ineligible for coverage under the Fund. In addition, if you or your dependent commits fraud or intentional misrepresentation on an enrollment form, in connection with a benefit claim or appeal, or in response to any request for information by the Fund (including any Claims Administrator), your coverage may be terminated retroactively (i.e., rescind your coverage) upon 30 days' notice. Failure to inform any such persons that you or your dependent is covered under another group health plan or knowingly providing false information in order to obtain (or continue) coverage for an ineligible dependent are examples of actions that constitute fraud under the Fund. A participant's or dependent's coverage may also be terminated retroactively (without notice) due to a failure to timely pay any premiums or self-pay contributions, including COBRA premiums. Failure to notify the Fund of a dependent losing eligibility (e.g. divorce or a child aging out) or that you lose other health coverage that you have said covers you and/or your dependents will be considered fraud or intentional misrepresentation and coverage will be terminated retroactively to the date of the event.

If coverage is terminated, you and/or your dependent may be required to repay to the Fund amounts incorrectly paid by the Fund. The Board of Trustees may commence legal action against you or any other individual for restitution and hold you or them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments for you or your dependents to recover amounts owed.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that this Plan offer you and your eligible dependents the opportunity to extend health care coverage at group rates in certain instances (called qualifying events) when coverage under the Plan would otherwise end. Coverage under COBRA is the same as the coverage described in this SPD.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that qualifying event that person's health care coverage ends, either as of the date of the qualifying event or as of some later date. Covered employees and retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child.



Under the law, a qualified beneficiary is any participant or retiree or the spouse or dependent child of a participant or retiree who is covered by the Plan when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered qualified beneficiary during a period of COBRA Continuation Coverage is also a qualified beneficiary. A child of the covered participant or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee’s period of employment, is entitled to the same rights under COBRA as an eligible dependent child. A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a “qualified beneficiary.” This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new spouse is not entitled to elect COBRA for him/herself.

Qualifying COBRA Events

Qualified Beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law) occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a qualifying event but, as a result, does not lose their health care coverage under this Plan, (e.g., employee continues working even though entitled to Medicare) then COBRA is not available.

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

IF COVERAGE WOULD OTHERWISE END BECAUSE	THESE PEOPLE WOULD BE ELIGIBLE FOR COBRA COVERAGE	UP TO (MEASURED FROM THE DATE COVERAGE WOULD HAVE ENDED)
Your employment terminates*	You and your covered spouse and children	18 months**
Your working hours are reduced	You and your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months
You divorce	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your covered child	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

*For any reason other than gross misconduct (including military leave and approved leaves granted according to the Family and Medical Leave Act)

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

Annual and Special Enrollment

COBRA beneficiaries are entitled to the same rights and enrollment opportunities under the Plan as active participants including Annual and Special Enrollment.

Multiple Qualifying Events

If your covered dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event. For example, if your employment ends, you and your covered dependents may be eligible for 18 months of continued coverage. If you die (a second qualifying event) during this 18-month period, your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination of employment).

Notice of COBRA Eligibility

Depending on the qualifying event, your employer, your eligible dependents or you must notify the Fund Office of the event no later than 60 days after coverage would have ended due to the event.

In the event of your death, termination of employment, reduction in hours of employment or Medicare entitlement, **your employer** must notify the Fund Office. However, you or your family should also notify the Fund Office if such an event occurs, in order to avoid confusion as to your status.

You and/or your eligible dependents are responsible for informing the Fund Office as soon as possible, but not later than 60 days, after coverage would have ended due to one of the following:

- divorce
- a child ceasing to be a dependent
- a second qualifying event that entitles an eligible dependent to additional COBRA coverage
- a dependent being determined to be disabled under Social Security
- a dependent who had been disabled under Social Security receiving notice that he or she is no longer considered disabled.

If you do not notify the Fund Office within 60 days, you or your dependents, as applicable, will not be eligible for COBRA coverage, and you will be responsible for any claims incurred by you or your dependents after the date of the applicable qualifying event.

The notice of COBRA eligibility must include the following:

- your name
- the names of your dependents
- your Social Security number and the Social Security numbers of your dependents
- your address
- the nature and date of the occurrence you are reporting along with proof of the event
- if the event is a divorce, a copy of the divorce decree
- if you are requesting a disability extension, the name of the disabled person and a copy of the disability determination letter from the Social Security Administration



To elect COBRA continuation coverage, you must select coverage within the stated time frame and pay for that coverage by the deadline.



- if you are reporting a second qualifying event, the name of the qualified beneficiary(ies) and the date and proof of the second qualifying event (for example, a copy of a divorce decree).

The Fund Office must notify you and/or your covered dependents of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. In the event the Plan is notified of a qualifying event but determines the individual is not entitled to COBRA Coverage, the Plan will send an explanation that COBRA Coverage is not available. Full details of COBRA coverage will be furnished. You will then have 60 days to respond if you want to continue coverage—measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you.

Alternatives to COBRA

You may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. In addition, in the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA doesn't limit your eligibility for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that Plan within 30 days, even if that plan generally does not accept late enrollees.

Paying for COBRA Coverage

You have to pay the full cost of continued coverage under COBRA, plus a 2% administrative fee. **Note that family rates apply if COBRA coverage is elected for two or more people in a family.** (If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge 150% of the full cost of the Plan during the 19th to 29th month of coverage.) The following rules apply to making your COBRA payments:

- You can make your first payment when you file your COBRA election form, that is, within 60 days after the date your Plan coverage would otherwise end. In no event, however, may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended (and COBRA coverage began) through the current month.
- All subsequent payments will be due on the first day of each month for that month's coverage (for example, June 1 for June coverage). Keep in mind that although the Fund Office sends monthly reminders that payment for COBRA coverage is due, **it is your responsibility to see that your payment is at the Fund Office by the due date, whether or not you receive such reminder from the Fund Office.**
- There is a 30-day grace period for all subsequent payments. (For example, the grace period for payment for June ends on June 30.) However, if you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Fund Office receives your payment for the month.

For your convenience, the Fund Office sends monthly reminders that payment for COBRA coverage is due. However, it is still your responsibility to make COBRA payments on time, whether or not you receive such reminder. If you do not pay on time, your coverage will end.

COBRA premiums are generally reviewed at least once a year and are subject to change. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

When COBRA Coverage Ends

Continued coverage under COBRA will end for any of the following reasons:

- Coverage has continued for the maximum 18-, 29- or 36-month period, measured from the date coverage is lost.
- The Plan terminates. If the coverage is replaced, your coverage may continue under the new plan.
- You or your dependent(s) fail to make the necessary payments on time.
- You or your covered dependent(s) become covered under another group health plan after the COBRA election.
- You or a covered dependent becomes entitled to benefits under Medicare after the COBRA election.
- You or your dependent(s) are continuing coverage from the 19th to 29th month of a disability, and the disability ends.

If COBRA ends before maximum period, the Fund will notify you. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early. Once COBRA coverage terminates early, it cannot be reinstated.

COBRA Questions or to File Notice of Changes to Your Circumstances

If you have any questions about your COBRA rights, please contact the Fund Office. For more information about your rights under the Employees Retirement Income Security (ERISA), including COBRA, the Patient Protection and Affordable Care Act (PPACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Special Note

If your employment is terminated or you experience a reduction of hours due to a Trade Act Adjustment Assistance event, special COBRA election rules may apply. You may also qualify for a tax credit for a percentage of your cost for COBRA coverage. More information is available online at www.doleta.gov/tradeact/. You may also be entitled to certain subsidized COBRA benefits under federal or state law; read your COBRA notice carefully for information regarding such programs.



Hospital And Health Benefits through Empire Blue Cross Blue Shield

Hospital and Medical Benefits are provided by Empire BlueCross BlueShield, and include Blue Cross network providers throughout the country.

Your health and hospital benefits under Plan C depend on the medical option you select. Empire BlueCross BlueShield administers coverage under Plans C-1, C-2, C-3 and C-4. Each of the four options provides a comprehensive package of hospital and health care benefits. Plans C-1 and C-2 are **preferred provider organizations (PPOs)**, which means they offer you a choice of using an in-network or out-of-network provider each time you or a covered dependent needs medical care. You are covered for medically necessary services no matter which you choose. Plans C-3 and C-4 provide coverage through an **exclusive provider organization (EPO)**, which means benefits are paid only if you use in-network doctors and hospitals.

Both the PPOs and the EPO offer a network of health care providers available to you through Empire. Health care providers include doctors, hospitals, laboratories and other medical facilities that provide health care services. Some health care providers contract with health plans like Empire to provide services to members as part of the plan's "network."

Managing Your Health Care Online

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

- check status of claims
- search for doctors and specialists
- update your member profile
- get health information and tools with My Health powered by WebMD
- print plan documents
- receive information through your personal "Message Center."

What You Need to Do

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

- Go to www.empireblue.com.
- Click on the Member tab and choose "Register."
- Follow the simple registration instructions.

How to Reach Empire

You can contact Empire three different ways:

- **E-mail:** You can e-mail Empire with a question 24 hours a day, seven days a week. A customer service representative will e-mail an answer back to you through your Message Center.
- **Collaboration:** An Empire representative will call you while you are online and navigate the site with you. The representative can even take control of your mouse, making it easier to answer your questions.
- **Call Back:** You can request that a representative contact you with assistance.

Get Personalized Information

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

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit www.empireblue.com. Empire understands that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially. Nervous about using your PC for important healthcare questions or transactions? Empire has addressed that too! Just send them an e-mail.

BY TELEPHONE

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	1-800-553-9603 TDD for hearing impaired: 1-800-241-6894 8:30 a.m. to 5:00 p.m. Eastern time Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	1-800-553-9603 Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	1-800-810-BLUE (2583) www.bcbs.com 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	1-800-982-8089 8:30 a.m. to 5:00 p.m. Eastern time Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	1-877-TALK-2RN (825-5276) 24 hours a day, 7 days a week
FRAUD HOTLINE	Help prevent health insurance fraud	1-800-I-C-FRAUD (423-7283) 9:00 a.m. to 5:00 p.m. Eastern time Monday – Friday



IN WRITING

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

Your Identification Card

When you enroll in Plan C-1, C-2, C-3, or C-4, you will receive an identification card from Empire that you can use for all your Empire health insurance services. Always carry it and show it each time you receive health care services. Every covered member of your family will get his or her own card. The information on your card includes your name, identification number and various copay amounts.

Plan Basics

The key to using your Plan is understanding how benefits are paid.

- If you are enrolled in Plan C-1 or C-2, start by choosing in-network or out-of-network services any time you need health care. Your choice determines the level of benefits you will receive.
- If you are enrolled in Plan C-3 or C-4, you must use a provider in the Empire network or one covered through the BlueCard® PPO Program (see page 67). There are no out-of-network benefits under these Plan options.

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

Use Your Plan to Your Best Advantage

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

- Be sure you know what is covered. That way, you and your doctor are better able to make decisions about your health care. Empire will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the Plan applies to certain types of care.
- Remember to precertify hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.

- Ask questions about your health care options and coverage. To find answers, you can:
 - read this SPD
 - call Empire’s Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply
 - call 24/7 NurseLine and AudioHealth Library — available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss health care options and more.

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

Health Management

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

- Precertification and the Medical Management Program
- Case Management
- Health and Wellness Solutions.

Precertification and the Medical Management Program

Empire’s Medical Management Program, a service that pre-certifies hospital admissions and certain treatments and procedures, helps ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Empire’s Medical Management Program works with you and your provider to help confirm the medical necessity of services and help you make sound health care decisions. The program helps ensure that you and your family members receive the highest quality of care at the right time, in the most appropriate setting.

You can contact Empire’s Medical Management program by calling the Member Services telephone number located on the back of your identification card.

To help ensure that you receive the maximum coverage available to you, Empire’s Medical Management Program

- Reviews all planned and emergency hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements.
- Reviews inpatient and same day surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice or skilled nursing or other facility.

All other services will be subject to retrospective review by our Medical Management team to determine medical necessity.

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

WHEN PRECERTIFICATION IS REQUIRED	HOW COVERED	WHO CALLS TO PRE-CERTIFY
<p>For All Hospital Admissions</p> <ul style="list-style-type: none"> • At least two weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission • For illness or injury to newborns 	In-network and Out-of-Network	You or Your Provider
<p>For Pregnancy</p> <ul style="list-style-type: none"> • As soon as reasonably possible; Empire requests notification within the first three months of pregnancy, when possible <p>For Delivery</p> <p>Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth.</p>	In-network and Out-of-Network	You
<p>Before You Receive/Use</p> <ul style="list-style-type: none"> • Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification • Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs • Occupational, physical, speech and vision therapy • Outpatient/ Same Day Surgical Treatments (certain procedures) • Diagnostic • Outpatient Treatments • Durable medical equipment • Air ambulance • Genetic testing 	In-network and Out-of-Network	You
<p>Before You Receive</p> <ul style="list-style-type: none"> • Occupational or speech therapy • Outpatient physical therapy • Skilled nursing facility care 	In-network only	You
<p>Before You Rent</p> <ul style="list-style-type: none"> • Prosthetics, orthotics or durable medical equipment 	<p>Empire Network</p> <hr/> <p>BlueCard PPO Network</p>	<p>Network Supplier</p> <hr/> <p>You</p>
<p>Before You Receive MRIs/MRAs</p> <ul style="list-style-type: none"> • It is the provider’s responsibility to call Empire for precertification of all in-network MRIs/MRAs. 	<p>Empire Network</p> <hr/> <p>BlueCard PPO Provider</p> <hr/> <p>Out-of-Network</p>	<p>Provider</p> <hr/> <p>Provider</p> <hr/> <p>You</p>

IF SERVICES ARE NOT PRE-CERTIFIED

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to \$5,000 for each admission, treatment or procedure. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

WHAT YOU WILL NEED WHEN YOU CALL

Have the following information about the patient ready when you call:

- name, birth date and sex
- address and telephone number
- Empire ID card number
- name and address of the hospital/facility
- name and telephone number of the admitting doctor
- reason for admission and nature of the services to be performed.

INITIAL DECISIONS

Empire will comply with the following timeframes in processing precertification, as well as concurrent and retrospective requests for review of services.

Preauthorization Reviews

a. Non-Urgent Preauthorization Reviews If Empire has all the information necessary to make a determination regarding a preauthorization review, Empire will make a determination and provide notice to you (or your designee) and your provider, in writing, within fifteen (15) calendar days of receipt of the request.

If Empire needs additional information, they will request it within fifteen (15) calendar days. You or your provider will then have 45 calendar days to submit the information. If Empire receives the requested information within 45 days, they will make a determination and provide notice to you (or your designee) and your provider, in writing, within fifteen (15) calendar days of their receipt of the additional information. If all necessary information is not received within 45 days, Empire will make a determination within 15 calendar days of the end of the 45-day period allowed to submit the additional information.

b. Urgent Preauthorization Reviews With respect to urgent preauthorization requests, if Empire has all information necessary to make a determination, they will make a determination and provide notice to you (or your designee) and your provider, in writing, within 72 hours of receipt of the request.

If Empire needs additional information, Empire will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Empire will make a determination and provide notice to you (or your designee) and your provider, in writing, within 48 hours of the earlier of Empire's receipt of the additional information or the end of the 48-hour period allowed to submit additional information.





c. Court Ordered Treatment With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, Empire will make a determination and provide notice to you (or your designee) and your provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Empire's receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

Concurrent Reviews

1. Non-Urgent Concurrent Reviews Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

If Empire needs additional information, Empire will request it within fifteen (15) calendar days of the receipt of the request. You or your provider will then have 45 calendar days to submit the additional information. Empire will make a determination and provide notice to you (or your designee) and your provider, in writing, within fifteen (15) calendar days of Empire's receipt of the additional information or, if Empire does not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

2. Urgent Concurrent Reviews For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, Empire will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, Empire will make a determination and provide written notice to you (or your designee) and your provider within 72 hours of receipt of the request. If Empire needs additional information, Empire will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Empire will make a determination and provide written notice to you (or your designee) and your provider within the earlier of one (1) business day or 48 hours of Empire's receipt of the information or, if Empire does not receive the information, within 48 hours of the end of the 48-hour period.

3. Inpatient Substance Use Disorder Treatment Reviews If a request for inpatient substance use disorder treatment is submitted to Empire at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, Empire will make a determination within 24 hours of receipt of the request and they will provide coverage for the inpatient substance use disorder treatment while the determination is pending.

Retrospective Reviews

If Empire has all information necessary to make a determination regarding a retrospective claim, Empire will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If Empire needs additional information, Empire will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. Empire will

make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of their receipt of the information or the end of the 45-day period.

Once Empire has all the information to make a decision, their failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

1. Retrospective Review of Preauthorized Services Empire may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Empire upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to Empire upon retrospective review existed at the time of the preauthorization but was withheld or not made available to Empire;
- Empire was not aware of the existence of such information at the time of the preauthorization review; and
- Had Empire been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

If Empire's Medical Management Program does not meet the above timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

IF A REQUEST IS DENIED

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See Claims and Appeals Procedures, which begins on page 119, for more information.

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

REQUESTING COVERAGE FOR NEW MEDICAL TECHNOLOGY

Empire uses a committee composed of Empire Medical Directors (doctors and participating in-network physicians) to continuously evaluate new medical technologies that have not yet been designated as covered services.

If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire's Medical Management Program. The provider will be asked to provide:

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

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

Case Management

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

- find appropriate, cost-effective health care options
- reduce medical cost
- assure quality medical care.

A Case Manager serves as a single source for patient, provider and insurer—assuring that the treatment, level of care and facility are appropriate for your needs. Case Management typically helps with cases such as cancer, stroke, AIDS, chronic illness, hemophilia and spinal and other traumatic injuries.

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire's staff will initiate a review of a patient's health status and the attending doctor's plan of care. If you would like Case Management assistance following an illness or surgery, contact Empire at 1-800-982-8089.

Empire may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Empire's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services. In addition, Empire may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Empire may also exempt your claim from medical review if certain conditions apply. Just because Empire exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that Empire will do so in the future, or will do so in the future for any other provider, claim or participant. Empire may stop or modify any such exemption with or without advance notice. You may determine whether a provider is participating in certain programs by checking your on-line provider directory or contacting customer service at the number on the back of your ID card.

Health and Wellness Solutions

Empire's health services program, Health and Wellness Solutions®, helps you improve, manage and maintain your health.

No matter what your healthcare needs, as an Empire plan member you have access to programs and services to help you achieve and maintain your highest potential for good health—at no additional charge. Health and Wellness Solutions is a group of programs that surround you with personalized support. From preventive care to managing complex conditions, we are there when you need us.

Empire's Health and Wellness Solutions is organized into:

- Online health and wellness resources.
- Discounts on health-related products & services, and alternative therapies
- Guidance and support for when you need help

The following are descriptions of some of the programs and services available to you:

24/7 NurseLine and AudioHealth Library – receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call 1-877-Talk-2-RN (1-877-825-5276). If you need advice on comforting a baby in the middle of the night or need to locate a doctor, you can call the 24/7 NurseLine. Call the 24/7 NurseLine to:

- Assess and understand your symptoms.
- Find additional help to make informed healthcare decisions.
- Locate a doctor, hospital or other practitioner.
- Get information about an illness, medication or prescription.

- Find information about a personal health issue such as diet, exercise or high blood pressure
- Answer questions on pregnancy
- Get assistance with discharge from a hospital
- Help you decide if a medical situation requires emergency treatment.

You can also access an easy-to-use audio library. You can hear advice and news delivered in English and Spanish on several topics, from colds and sore throats to diabetes and cancer.

24/7 NurseLine is not for emergencies, so please do not call if you believe you or a family member

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

In these cases, call 911 or your local emergency service as soon as possible.

Here's how to use 24/7 NurseLine:

- Dial 1-877-Talk-2-RN (1-877-825-5276) and follow the prompts to speak with a nurse or listen to the audiotape messages.
- If you plan on listening to the tapes, have your member ID number handy. You will need to enter the first three digits. For example, if your number is YLD123456789, enter YLD (123). For members who do not speak English, stay on the line to be connected to an interpreter. If you have additional questions after listening to a tape, simply connect to the on-duty nurse.

Special Offers – Members can receive discounts on alternative medicine therapies and other health services. Go to the “Members” section of www.empireblue.com, look under Health Information, then select “Health and Wellness Solutions”, and click on “Special Offers”. You can get access to discounts for services and products such as:

- Services by Alternative Practitioners
- Wellness Products
- Fitness Club Membership
- Vision Services
- Weight Loss Programs

Please note that these services and products may not be available to your group and in all states, and are not covered benefits under your Empire healthcare plan. Empire makes no payment for these value-added programs available to you. Members pay the full amount of the provider's discounted fee.

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





Member Newsletter – Our semi-annual member newsletter, Healthy Solutions, contains a variety of articles on staying healthy and coping with chronic diseases such as diabetes and asthma as well as helpful information about your health plan.

Preventive Healthcare Guidelines – Distributed both in our member newsletter and available online at www.empireblue.com, these guides can help you and your family stay up-to-date on check-ups, immunizations, screenings and tests throughout every stage of your life.

My Health, powered by WebMD – This vast one-stop resource center of health information, services and tools is accessible to all eligible members through Member Online Services at www.empireblue.com. You will be able to find out if you are at risk for certain conditions, access the latest in health news, learn about treatments for common conditions and diseases, and much more. You will also find preventive healthcare guidelines including the important tests to take and discuss with your doctor. Topics include an online fitness program, **LEAP (Lifetime Exercise Adherence Program)**, where you can create your own personal fitness routine; **Ready, Set, Stop!**, a smoking cessation program that blends conventional smoking cessation techniques with an interactive experience; and the **Nutrition Center**, where you can increase your understanding of your diet and find ways to improve its nutritional value.

Here's how to get to "My Health":

- Go to www.empireblue.com.
- Register or log on to Member Online Services.
- Click on "My Health" at the top of the screen.



Hospital and Health Benefits

Terms You Should Know

Adverse determination is a communication from Empire’s Medical Management that reduces or denies benefits.

Annual maximum is the maximum amount the Plan will pay for covered expenses in one calendar year.

Annual out-of-pocket limit is the most you pay during a Benefit Period in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the “Benefits at a Glance” section for cost shares that apply to your Plan.

Authorized services – See “precertified services.”

Autism spectrum disorder (ASD) is any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including Autistic disorder, Asperger’s disorder, Rett’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

Case management refers to assistance and support available when you or a member of your family faces a chronic or catastrophic illness or injury.

Clinical Trials. The Plan will cover the routine patient costs for your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if you are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when you do not have cancer or other life-threatening disease or condition, may be subject to Utilization Review and External Appeal.

The Plan does not cover costs of the investigational drugs or devices; the costs of non-health services required for you to receive the treatment; the costs of managing the research; or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial; or
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or

A drug trial that is exempt from having to make an investigational new drug application.

Coinsurance is the percentage of a covered medical expense you pay.

Concurrent refers to a claim or review during treatment.

Conformity with Law. Any term of this SPD which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

Copayment, or Copay, is the fee you pay for office visits and certain covered services when you use in-network providers. The Plan then pays 100% of the remaining Covered Expenses.

Covered services are services for which Empire provides benefits under the terms of the Plan’s contract. For example, Empire covers one in-network annual physical exam per year. Certain frequency or other limitations may apply.

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

Fraud and Abusive Billing. Empire has processes to review claims before and after payment to detect fraud and abusive billing. Empire may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If Empire selects a Provider for review under this program, then as part of the review process, Empire may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan’s participants. Participants seeking services from out-of-network providers could be balance billed by the out-of-network provider for those services that are determined to be not payable due to a reasonable belief of fraud or other intentional misconduct or abusive billing.

Health Care Professional means an appropriately licensed, registered or certified physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this benefit plan.

Hospital/facility means, for purposes of certifying inpatient services, a hospital or facility must be a fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care

- Assigned emergency personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors
- For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.
- For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan.
- For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York’s. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.
- For behavioral healthcare purposes, the definition of “hospital” may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare services.
- For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.
- For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with Empire.
- Empire does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.

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

In-network provider/supplier is a doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- is in Empire’s PPO network
- is in the PPO network of another BlueCross and/or BlueShield plan, or
- has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a PPO network.





The defined terms are used to administer your medical benefits.

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

Lifetime maximum is the maximum amount of benefits your plan will pay for covered expenses over the course of your lifetime.

Maximum allowed amount is the maximum amount the Plan reimburses for services and supplies. In-network providers have agreed to accept the maximum allowed amount as payment in full for services. Out-of-network providers may bill you for amounts above the maximum allowed amount and you will be responsible for paying any amount charged above the maximum allowed amount. For more detail on the maximum allowed amount see the section “How Much You Will Pay—Maximum Allowed Amount” on page 67.

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

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

The Plan covers benefits described in this SPD as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that we have to cover it.

Empire will determine medical necessity based on a review of:

- Your medical records;
- Empire’s medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of you, your family, or your provider;
- They are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results;

When setting or place of service is part of the review, services that can safely be provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office or the home setting.

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

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

Out-of-network deductible means the amount you pay for services of out-of-network providers/suppliers before the Plan pays any benefits. Once your out-of-network deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called the **out-of-network coinsurance**, of Empire's maximum allowed amount for the out-of-network service. You are responsible for any amounts not covered, or which are in excess of the maximum allowed amount. You pay your out-of-network coinsurance up to an annual out-of-pocket limit. Once you meet your annual out-of-network out-of-pocket limit, you will not be required to pay coinsurance, but you will be responsible to pay the difference between the provider's actual charge and Empire's maximum allowed amount. This is not applied to the deductible and coinsurance amounts. Refer to the Benefits at a Glance section starting on page 3 for your out-of-network deductible, coinsurance and out-of-pocket limit.

Out-of-network provider/supplier is a doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- is not in Empire's PPO network,
- is not in the PPO network of another BlueCross and/or BlueShield plan, and
- does not have a negotiated rate with another BlueCross and/or BlueShield plan.

Participating hospital/facility is a hospital or facility that:

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

Precertified services are services that **must** be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by the Plan, such as planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.

Provider means a hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner’s license. For behavioral healthcare purposes, “provider” includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy. For maternity care purposes, “provider” includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Provider also means a Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies covered under this benefit plan that is licensed, registered, certified or accredited as required by law.

Retrospective review is one that is conducted after you receive medical services.

Same-day surgery means surgery performed in a hospital or other facility that does not require an overnight stay. For same-day surgery, the definition of “hospital” may include a free-standing ambulatory surgical facility that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan. “Facility” does not include a provider’s office.

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

Treatment of autism spectrum disorder is care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist.

Urgent precertification is one associated with medical circumstances that require a quick decision.

Voluntary Clinical Quality Programs seek to promote good health and the early detection of disease. They are designed to encourage participants to obtain certain covered Preventive Care or other recommended care covered by the Plan not received within the recommended timeframe. For instance, a program may be designed to encourage you to bring your child to his or her primary care physician for a well-child or well-baby care visit if you missed a recommended check-up, or may encourage you to get certain screening tests such as a mammogram if you have not been tested within the recommended age range. Or, a program may encourage you to have a medical visit within a specific time period such as a postpartum checkup within a set number of days after delivery of a newborn or a home visit so you can provide a blood sample for a recommended laboratory test.

These voluntary clinical quality programs are designed to encourage you to get certain preventive, wellness, or other recommended care when you need it based on recommended clinical guidelines. These programs are not guaranteed and your participation is optional. Empire will give you the choice, and if you choose to participate in any program for which you qualify, and obtain the recommended care within the program’s timeframe, you may receive an incentive. The incentive will take the form of:

- a gift card in the amount of \$50 or retailer coupons, such as for discounts on eye glasses; or
- a home test kit at no cost to allow you to conveniently collect a specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. In this case, you may need to pay any cost shares that normally apply to covered laboratory tests under your benefit plan, but the home test kit will be free to you; or

- a home visit to allow you to provide a specimen for certain covered laboratory tests, or for certain biometric screenings. In this care, you may need to pay any cost shares that normally apply to covered laboratory tests, but the home visit will be free to you.

If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, Empire recommends that you consult your tax advisor.

Eligibility. You, your covered Spouse, and each covered Dependent can participate in the Voluntary Clinical Quality Program(s) if the targeted service applies, based on the recommended clinical guidelines the program promotes. These programs will be offered to participants who have certain conditions, who fall within certain age ranges, or who are due to receive certain recommended preventive or other care based on a recommended timeframe. For example:

- Participants between ages 50-75 years who have not undergone colorectal cancer screening as recommended by the American Cancer Society may be eligible to participate in a program designed to encourage these members to obtain a recommended preventive colorectal cancer screening, such as a fecal occult blood screening test.
- Participants between ages 50-74 years who have not had a mammography screening as recommended by the United States Preventive Services Task Force may be eligible to participate in a program designed to encourage these members to obtain the screening through the offer of a gift card awarded upon receipt of documentation that the screening was completed.

Participation. If you are eligible for a clinical quality program that Empire offers, Empire will contact you by phone or mail to offer you the chance to participate. You may also call us at the phone number on your ID card if you have any questions regarding program participation. We will explain to you the care you are recommended to receive and the time frame within which you need to receive it to be eligible for the reward if applicable.

Rewards. Rewards for participation in a clinical quality program and completion of the identified services within the specified timeframe include monetary rewards in the form of a gift card or retailer coupon such as for discounts on eye glasses, so long as the recipient is encouraged to use the reward for a product or service that promotes good health. In other cases, you will receive a home test kit at no cost to make it more convenient for You to receive the recommended care. These programs are offered and administered by Empire; this Plan will not have any responsibility regarding your participation in these programs.





In-Network Services

In-network services are health care services provided by a doctor, hospital or health care facility that has been selected by Empire or another BlueCross and/or BlueShield plan to provide care to our members. With in-network care, you get these advantages:

- **Choice.** You can choose any in-network provider from a **large** network of doctors and hospitals.
- **Freedom.** You do not need a referral to see a specialist, so you direct your care.
- **Low cost.** Benefits are paid after a copay or deductible and coinsurance payment for office visits and many other services.
- **Broad coverage.** Benefits are available for a broad range of health care services, including visits to specialists, physical therapy and home health care.
- **Convenience.** Usually, there are no claim forms to file.

To access primary care services, simply visit any in-network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any in-network specialist you choose. Referrals are never needed to visit any in-network specialty care provider, obstetrician or gynecologist or for emergency services in an emergency room.

If you schedule an appointment with a new doctor, be sure to confirm that the doctor is an in-network provider and accepts new patients. If, during your visit, the doctor sends you to an outside lab or radiologist for tests or x-rays, call Empire's Member Services to confirm that the supplier is in Empire's network. This will ensure that you receive maximum benefits.

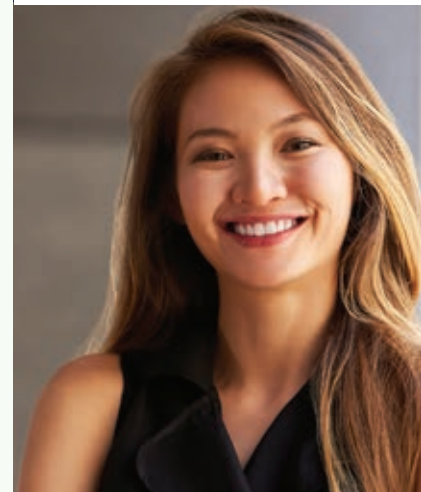
Out-of-Network Services – Only for Plans C-1 and C-2

Out-of-network services are health care services provided by a licensed provider outside Empire's PPO network or the BlueCard PPO network of other BlueCross and/or BlueShield plans. If you are enrolled in Plan C-1 or C-2, you can choose in-network or out-of-network for most services. However, some services are only available in-network. When you use out-of-network services, you will:

- pay an annual deductible and coinsurance, plus any amount above the maximum allowed amount (the maximum the Plan will pay for a covered service). If you use a BlueCard provider, you will pay only the lower of billed charges or a negotiated rate and your participant liability.
- usually have to pay the provider when you receive care
- need to file a claim to be reimbursed by Empire.

Here is an example of how costs compare for in-network and out-of-network care under Plan C-1.

	IN-NETWORK	OUT-OF-NETWORK
Provider's charge	\$200	\$500
Maximum allowed amount	\$150	\$400
Plan pays provider	\$130	\$200
You pay provider	\$20 copay	\$200 (25% of maximum allowed amount plus the \$100 above the maximum); assuming you have satisfied the deductible



Here is an example of how costs compare for in-network and out-of-network care under Plan C-2.

	IN-NETWORK	OUT-OF-NETWORK
Provider's charge	\$200	\$500
Maximum allowed amount	\$150	\$400
Plan pays provider	\$125, or \$120 (80% of maximum allowed amount), depending on the type of service	\$240 (60% of maximum allowed amount)
You pay provider	\$25 copay or \$30 (20% of maximum allowed amount), depending on the type of service	\$260 (40% of maximum allowed amount plus the \$100 above the maximum allowed amount; assumes you have satisfied the deductible)

Remember, Plans C-3 and C-4 pay benefits only for in-network care.

How to Find an In-Network Provider

If you live in or around eastern New York State, you can use any provider in Empire's local network. In addition, regardless of where you live in the U.S., you can use any provider that is part of the **BlueCard® Program**. The BlueCard is a national PPO that links BlueCross and/or BlueShield PPO providers and local BlueCross and BlueShield plans across the country. When you obtain medically necessary covered health care services from providers participating in the BlueCard Program, you receive the same benefits and the same in-network coverage across the country.

To locate a provider in Empire's operating area, visit www.empireblue.com. You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Or, ask your Benefits Administrator to see Empire's PPO Directory.

You can also request that a directory be mailed to you free of charge by calling Member Services at **1-800-553-9603** or visit www.bcbs.com to locate participating BlueCard PPO® providers.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Empire's Service Area

YOUR LIABILITY CALCULATION

When covered healthcare services are provided outside of Empire's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

EXCEPTIONS

In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

BLUECARD® PPO PROGRAM

Care When you are Out of Our Service Area Within the U.S.

If you are traveling outside the Empire service area, the BlueCard® PPO program lets you use other Blue Cross and/or Blue Shield plans' PPO networks of physicians, hospitals and other health care providers. You are automatically enrolled in the BlueCard® PPO program. This allows you to receive in-network benefits across the country outside of our network area from providers participating with other Blue Plans' PPO networks. As long as these services are covered services under your Contract or Certificate, they will be treated as in-network services. If you are traveling and need medical care, call 1-800-810-BLUE (2583), for the names and addresses of the PPO providers nearest you. You may also visit the Blue Cross and Blue Shield Association Web site to locate providers in other states at www.bcbs.com.

BLUECARD® Worldwide Program

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

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®1 Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the maximum allowed amount.

How Much You Will Pay—Maximum Allowed Amount

This section describes how Empire determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by in-network and out-of-network providers is based on the Maximum Allowed Amount for the covered service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet Empire's definition of Covered Services, to the extent such services and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in the Plan.



BlueCard providers are network doctors and medical specialists located throughout the United States and Worldwide. Call 1-800-810-BLUE (2583) or look online at www.bcbs.com to locate network providers.



You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, or have a Copayment or Coinsurance.

Under Plans C-3 and C-4, services received from an Out-of-Network Provider are not covered except for Emergency Care. If you receive Covered Services from an Out-of-Network Provider, in an emergency or when authorized, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, Empire will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Empire's determination of the Maximum Allowed Amount. Empire's application of these rules does not mean that the Covered Services you received were not Medically Necessary; it means Empire determined that the claim submitted was inconsistent with procedure coding rules and/or their reimbursement policies. For example, your Provider may have submitted a claim using several procedure codes when there is a single procedure code that includes all of the services that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, Empire may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

In-Network and Out-of-Network Services

The maximum allowed amount varies depending upon whether the provider is in-network or out-of-network.

IN-NETWORK SERVICES

For in-network covered services, the maximum allowed amount is the rate the provider has agreed with Empire to accept as reimbursement. Because in-network providers have agreed to accept the maximum allowed amount as payment in full for that service, you will not have to pay any amount above the maximum allowed amount. However, you may have to pay all or a portion of the maximum allowed amount for a service or item if you have not met your deductible or have a copay or coinsurance.

OUT-OF-NETWORK SERVICES

For out-of-network covered services, the maximum allowed amount will be based on Empire's out-of-network provider fee schedule/rate or the out-of-network provider's charge, whichever is less. The Fund's payment obligation will not exceed actual billed charges.

The maximum allowed amount for out-of-network covered services is based on Empire's fee schedule/rate, developed by reference to one or more of several sources, including the following amounts or a percentage of the following amounts:

- amounts based on Empire's in-network provider fee schedule/rate
- amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services (CMS), unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually.
- amounts based on charge, cost reimbursement or utilization data
- amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable providers' fees and costs to deliver care, or
- an amount negotiated by the Claims Administrator or a third party vendor that has been agreed to by the provider. This may include rates for services coordinated through Case Management.

In the case of emergency medical services received in an out-of-network emergency room the maximum allowed amount will be the highest of the amounts listed above.

Unlike network providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds Empire's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the provider charges. This amount can be significant. Please call customer service for help in finding in-network providers or visit Empire's website at www.empireblue.com.

You can obtain the maximum allowed amount for a particular service by calling the Empire Customer Service number on the back of your identification card. In order for Empire to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this information before you obtain services, the final maximum allowed amount for your claim will be based on the actual claim submitted.

OUT-OF-NETWORK SERVICES REIMBURSED BASED ON IN-NETWORK COST SHARING (UP TO THE MAXIMUM ALLOWED AMOUNT) UNDER CERTAIN CIRCUMSTANCES

As described below, you may be reimbursed for out-of-network services based on the in-network cost sharing for any amount billed up to the maximum allowed amount under the following circumstances:

- emergency care
- you had no control over the selection of an out-of-network provider
- no in-network provider was available

However, in all of these situations you will also have to pay any amount charged in excess of the maximum allowed amount.

Emergency Care. If you obtain covered emergency medical services for emergency care, even if you are unable to contact Empire before the services are rendered, benefits will be payable based on the in-network cost share, but only up to the maximum allowed amount. However, you will still have to pay any amount billed by the provider above the maximum allowed amount. See the examples below as to what you would have to pay in such a situation.

You Had No Control over the Selection of an Out-of-Network Provider. In some instances when you have no control over the selection of an out-of-network provider, you will be reimbursed at the in-network cost share amounts (deductible, copay and/or coinsurance), but only up to the maximum allowed amount. For example, if you go to an in-network hospital/facility and receive covered services from an out-of-network provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an in-network hospital/facility, you will be charged only the applicable in-network deductible, copay and/or coinsurance. However, you will have to pay the full amount charged over the maximum allowed amount.

No In-Network Provider is Available. In some circumstances, when there is no in-network provider available for a covered service, the Plan will reimburse you based on the applicable in-network cost-sharing amount (deductible, copay or coinsurance) up to the maximum allowed amount even if you have to use an out-of-network provider. However, you will still have to pay the entire amount charged above the maximum allowed amount. You must contact Empire in advance of obtaining the covered service to obtain approval for this benefit. Please contact Customer Service for information or to request the required precertification.

Authorized Services. In some circumstances, such as where there is no In-Network Provider available for the Covered Service, Empire may authorize the In Network cost share amounts (Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Empire in advance of obtaining the Covered Service. Empire will authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care services from an Out-of-Network Provider consistent with applicable state and federal regulations on Emergency Services. If we authorize a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

What Is Covered

The Plan covers a broad range of health care services, including:

- doctor's services
- emergency care
- maternity care and infertility treatment
- hospital services
- durable medical equipment and supplies
- skilled nursing and hospice care
- home health care
- physical, occupational, speech and vision therapy
- behavioral health care

Details about these services and supplies is described in the sections that follow the Summary of Benefits chart.

Doctor's Services

Whether you are enrolled in Plan C-1, C-2, C-3, or C-4 the same doctor's services are covered. The difference among the Plans is that each Plan pays a different level of benefits, and Plans C-3 and C-4 pay benefits only for in-network providers and services.

Preventive Care

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many Preventive Care Services are covered by this Benefit Program with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. These services fall under four broad categories as shown below:

1. Items or services with an “A” or “B” rating from the United States Preventive Services Task Force; Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - d. High blood pressure;
 - e. Type 2 diabetes mellitus;
 - f. Cholesterol; and/or
 - g. Child and adult obesity.
2. Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations, including the well-child care immunizations as listed below:
 - a. DPT (diphtheria, pertussis and tetanus);
 - b. Polio;
 - c. MMR (measles, mumps and rubella);
 - d. Varicella (chicken pox);
 - e. Hepatitis B Hemophilus;
 - f. Tetanus-diphtheria;
 - g. Pneumococcal;
 - h. Meningococcal Tetramune; and/or
 - i. Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives
3. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) including:
 - a. Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child’s age;
 - b. Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:
 - i. For individuals who are:
 1. Ages 52 through 65 - 1 baseline;
 2. Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis);
 3. Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

For individuals who meet the criteria of the above programs, including one or more of the following:

- Previously diagnosed with or having a family history of osteoporosis
- Symptoms or conditions indicative of the presence or significant risk of osteoporosis
- Prescribed drug regimen posing a significant risk of osteoporosis
- Lifestyle factors to such a degree posing a significant risk of osteoporosis
- Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

4. Women's Preventive: Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- a. Well-woman care visits to a gynecologist/obstetrician;
- b. Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one;
- c. Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants, as well as injectable contraceptives;
- d. Breastfeeding support, supplies, and counseling: Covered in full when received from an In-Network Provider. Benefits for breast pumps are limited to one pump per pregnancy;
- e. Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at www.empireblue.com, or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

What's Covered

Covered services are listed in the Benefits at a Glance section starting on page 3. Following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury
- Diabetes supplies prescribed by an authorized including, but not limited to:
 - Blood glucose monitors, including monitors for the legally blind
 - Testing strips
 - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
 - Oral agents for controlling blood sugar
 - Data management systems

- Diabetes self-management education and diet information, including:
 - Education by a physician, certified nurse practitioner or member of their staff: at the time of diagnosis, when the patient’s condition changes significantly, or when medically necessary
 - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
 - Home visits for education when medically necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care
- Coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of Autism Spectrum Disorder:
 - Screening and Diagnosis. The Plan will provide coverage for assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.
 - Behavioral health treatment. The Plan will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed provider. The Plan will provide such coverage when provided by a licensed provider. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments (over the duration of the intervention) in objective and measurable terms.
 - Applied Behavior Analysis (ABA). The Plan will provide coverage for Applied Behavior Analysis, when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the state in which the provider practices.
 - Psychiatric and Psychological care. The Plan will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
 - Therapeutic care. The Plan will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat Autism Spectrum Disorder and when the services provided by such providers are otherwise covered under this Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Plan.
 - Assistive communication devices (ACDs). The Plan will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, the Plan may provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. The Plan will only cover devices that generally are



not useful to a person in the absence of a communication impairment. The Plan will not cover items such as, but not limited to, laptops, desktops, or tablet computers. The Plan may cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Empire will determine whether the device should be purchased or rented. Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per covered device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. The Plan will not provide coverage for delivery or service charges, or for routine maintenance.

The Plan will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

Please refer to the Health Management section for details regarding precertification requirements.

What Is Not Covered.

In addition to services mentioned under "What's Not Covered" in the other sections, this Plan does not cover the following:

- Dental services, including but not limited to:
 - Cavities and extractions
 - Care of gums
 - Bones supporting the teeth or periodontal abscess
 - Orthodontia
 - False teeth
 - Treatment of TMJ that is dental in nature
 - Orthognathic surgery that is dental in nature

However, your plan does cover:

- Surgical removal of impacted teeth
- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury
- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
 - Experimental or investigative
 - Obsolete or ineffective
 - Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:
 - Not of proven benefit

- Not generally recognized by the medical community (as reflected in published medical literature)
- Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person’s condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:
 - There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient’s particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
 - Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes
 - Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects)
 - Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.
- Services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
 - Specific services covered in a special agreement between Empire and a government hospital
 - United States Veterans’ Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.
- Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.
- Inappropriate Billing
- Services usually given without charge, even if charges are billed
- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified
- Medically Unnecessary Services
- Services, treatment or supplies not medically necessary in Empire’s judgment. See Terms You Should Know on page 57 and Glossary on page 147 for more information.
- All prescription drugs and over the counter drugs, self-administered injectables , vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated.
- Reversal of sterilization
- Assisted reproductive technologies including but not limited to
 - In-vitro fertilization
 - Gamete and zygote intrafallopian tube transfer
 - Intracytoplasmic sperm injection
 - Travel, even if associated with treatment and recommended by a doctor
 - Vision Care
 - Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated

- Services for illness or injury received as a result of war
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs

If You Need Emergency Care

Emergency care is covered in the hospital emergency room or an urgent care facility.

To be covered as emergency care, the condition must be a medical or behavioral 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:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. With respect to an emergency medical condition, the term "Stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta).

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 NurseLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week. You can also use Live Health Online.

Emergency Assistance 911

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

You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same co-payment as for an office visit.

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

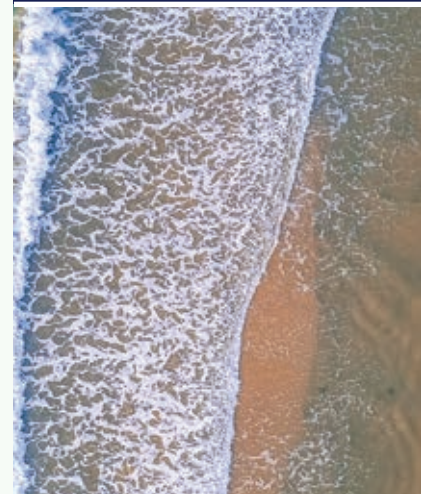
Remember: You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

Tips For Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment

- If you have an emergency while outside Empire’s service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard® PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard® Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

Please refer to the Health Management section starting on page 46 for details regarding precertification requirements.



What’s Not Covered

These emergency services are not covered:

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

Emergency Air Ambulance

The Plan will provide in-network coverage for air ambulance services when needed to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care, subject to cost sharing obligations, when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health
- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the amount that would be paid for land ambulance to that hospital. You may be required to pay the difference between the maximum allowed amount and the total charges of an out-of-network provider.

Please refer to the Health Management section for details regarding precertification requirements.

Emergency Land Ambulance

We will provide coverage for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in

- placing the member's health afflicted with a condition in serious jeopardy, or for behavioral condition, place the health of a member or others in serious jeopardy; or
- serious impairment to a person's bodily functions,
- serious dysfunction of any bodily organ or part of a person; or
- serious disfigurement to the member.

Benefits are not available for transfers of covered members between healthcare facilities.

Non-Emergency Ambulance Transportation

We cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute Facility to a sub-Acute setting.

Limitations/Terms of Coverage

- We do not cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by us, even though prescribed by a Physician.
- We do not cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:
 - The point of pick-up is inaccessible by land vehicle; or
 - Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Maternity Care

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

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

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

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

Newborns' and Mothers' Health Protection Act Of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict 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 or 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 Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Covered Benefits for Maternity

Covered services are listed in Your Benefits at a Glance section starting on page 3. Following are additional covered services and limitations:

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother.
- Semi-private room

Please refer to the Health Management section for details regarding precertification requirements.

What's Not Covered

These maternity care services are not covered:

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

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



Infertility Treatment

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations. Whether you are enrolled in Plan C-1, C-2, C-3, or C-4, the same infertility treatment services are covered. The difference among the Plans is how much you will pay out of pocket. Here is a list of covered infertility treatment services:

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

What Is Not Covered.

Services must be medically necessary and must be received from eligible providers as determined by Empire. In general, an eligible provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

The Plan will not cover any services related to or in connection with:

- In-vitro fertilization
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Reversal of elective sterilizations, including vasectomies and tubal ligations
- Cloning
- Medical or surgical services or procedures that are experimental
- Services to diagnose or treat infertility if Empire determines, in their sole judgment, that the service was not medically necessary.

Hospital Services

The Plan covers medically necessary care when you stay at a hospital for surgery or treatment of illness or injury. The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the Medical Management section for additional information.

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

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

Whether you are enrolled in Plan C-1, C-2, C-3, or C-4, the same hospital services are covered. The difference among the Plans is how much you will pay out of pocket.

Pre-Surgical Testing

Benefits are available for pre-surgical testing on an outpatient basis, when performed at the Hospital where the surgery is scheduled to take place, if:

- reservations for a Hospital bed and for an operating room at that Hospital have been made prior to performance of the tests;
- the Covered Person's doctor has ordered the tests; and
- proper diagnosis and treatment require the tests.

The surgery must take place within seven days after these tests. If surgery is canceled because of these pre-surgical test findings or as a result of a voluntary second opinion on surgery, the Plan will still cover the cost of these tests, but they will not be covered when the surgery is canceled for any other reason.

Tip For Getting Hospital Care

If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Covered Inpatient and Outpatient Care

Here is a list of hospital services covered and limitations under Plans C-1, C-2, C-3, and C-4 for both inpatient and outpatient (same-day) care:

- diagnostic x-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- anesthesiologist, including one consultation before surgery and services during and after surgery
- blood and blood derivatives for emergency care, same-day surgery or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, when preapproved by Empire's Medical Management Program (your provider must call to precertify these services). You must call to precertify out-of-network MRIs/MRAs.
- PET/CAT scans and nuclear cardiology services.

Please refer to the Health Management section for details regarding precertification requirements.

Covered Inpatient Care

Here is a list of additional hospital services under Plans C-1, C-2, C-3, and C-4 for inpatient care:

- semi-private room and board when the patient is under the care of a physician, and a hospital stay is medically necessary. (Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified.)
- operating and recovery rooms
- special diet and nutritional services while in the hospital
- cardiac care unit
- services of a licensed physician or surgeon employed by the hospital
- care related to surgery
- breast cancer surgery (lumpectomy, mastectomy), including:
 - reconstruction following surgery
 - surgery on the other breast to produce a symmetrical appearance
 - prostheses
 - treatment of physical complications at any stage of a mastectomy, including lymphedemas
- use of cardiographic equipment
- drugs, dressings and other medically necessary supplies
- social, psychological and pastoral services
- reconstructive surgery associated with injuries unrelated to cosmetic surgery
- reconstructive surgery for a functional defect which is present from birth
- physical, occupational, speech and vision therapy including facilities, services, supplies and equipment
- facilities, services, supplies and equipment related to medically necessary medical care.

Please refer to the Health Management section starting on page 46 for details regarding precertification requirements.

Reconstructive Surgery

Under the Women's Health and Cancer Rights Act of 1998 (WHCRA), group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Benefits for reconstructive breast surgery following a mastectomy will be provided in a manner determined in consultation with the attending physician and the patient, and include:

- all stages of reconstruction of the breast on which a mastectomy is performed
- reconstructive surgery on the other breast to produce a symmetrical appearance
- breast prostheses and surgical bras following a mastectomy, and
- physical complications of any stage of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Plan Administrator at (212) 580-9092 in New York or (800) 456-FUND (3863) outside New York.

What Is Not Covered. Inpatient services that are not covered include but are not limited to:

- private duty nursing
- private room. If you use a private room, you will pay the difference between its cost and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your deductible or coinsurance maximum.

- diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
- services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums or infirmaries at schools, colleges or camps
- any part of a hospital stay that is primarily custodial
- elective cosmetic surgery or any related complications
- hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility as defined in the Terms You Should Know section beginning on page 57.

Outpatient Care

Here is a list of additional covered hospital services for outpatient (same-day) care:

- same-day and hospital outpatient surgical facilities
- surgeons
- surgical assistant if none is available in the hospital or facility where the surgery is performed, and the surgical assistant is not a hospital employee
- chemotherapy and radiation therapy, including medications in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
 - at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis). Any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered.
 - in a hospital-based or freestanding facility as defined in the glossary

Please refer to the Health Management section for details regarding precertification requirements.

What Is Not Covered. Outpatient services that are not covered include but are not limited to:

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

When You Need Hospital Care

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

Durable Medical Equipment And Supplies

Plan C covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from in-network suppliers only. An Empire in-network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Empire's Member Services at (800) 553-9603. Out-of-network benefits are not available for these products.

Disposable medical supplies, such as syringes, are covered up to the maximum allowed amount whether you obtain them in network or **out of network**. Enteral formulas or other dietary supplements for certain severe conditions are also covered in and **out of network**

Whether you are enrolled in Plan C-1, C-2, C-3, or C-4, the same durable medical equipment and supplies are covered. The difference among the Plans is how much you will pay out of pocket. (See the "Benefits at a Glance" section beginning on page 3.) Here is a list of covered durable medical equipment and supplies under Plans C-1, C-2, C-3, and C-4:

- prosthetics, orthotics and durable medical equipment from in-network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
 - artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
 - prescription lenses, if organic lens is lacking
 - supportive devices essential to the use of an artificial limb
 - corrective braces
 - wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
- rental (or purchase when more economical) of medically necessary durable medical equipment
- replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician
- reasonable cost of repairs and maintenance for covered medical equipment
- medical supplies, such as catheters, oxygen and syringes
- enteral formulas with a written order from a physician or other licensed health care provider that states that the formula is medically necessary and effective, and without the formula, the patient would become malnourished, suffer from serious physical disorders or die
- modified solid food products for the treatment of certain inherited diseases with a written order from a physician or other licensed health care provider.

What Is Not Covered

Equipment that is not covered includes but is not limited to:

- air conditioners or purifiers
- humidifiers or dehumidifiers
- exercise equipment
- swimming pools
- false teeth
- hearing aids.



Skilled Nursing And Hospice Care

You are covered under Plan C for inpatient care in a skilled nursing facility or hospice. Benefits are available for in-network facilities only.

Whether you are enrolled in Plan C-1, C-2, or C-3, the same skilled nursing and hospice care services are covered. The difference among the Plans is how much you will pay out of pocket. (See Benefits at a Glance on pages 3-12.) If you enroll in Plan C-4, skilled nursing services are not covered.

Skilled Nursing Care

You are covered for up to 60 days per calendar year for inpatient care in an in-network skilled nursing facility if you need medical care, nursing care or rehabilitation services and:

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

What Is Not Covered

Skilled nursing facility care that primarily does any of the following is not covered:

- gives assistance with daily living activities
- is for rest or for the aged
- treats drug addiction or alcoholism
- provides convalescent care
- provides sanitarium-type care
- provides rest cures.

Hospice Care

Plan C covers up to 365 days of hospice care. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be



provided in a hospice, in the hospice area of an in-network hospital or at home, as long as it is provided by an in-network hospice agency. Covered hospice care services include:

- up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- medical care given by the hospice doctor
- drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
- physical, occupational, speech and respiratory therapy when required for control of symptoms
- laboratory tests, x-rays, chemotherapy and radiation therapy
- social and counseling services for the patient's family, including bereavement counseling visits until one year after death
- transportation between home and hospital or hospice when medically necessary
- medical supplies and rental of durable medical equipment
- up to 14 hours of respite care in any week.

Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network.

You are covered for up to 200 home health care visits per calendar year (combined in-network and out-of-network visits for Plan C-1 or C-2). A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.

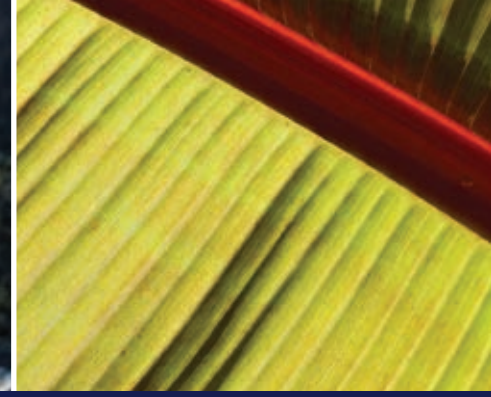
Whether you are enrolled in Plan C-1, C-2, C-3, or C-4, the same home health care services are covered. The difference among the Plans is how much you will pay out of pocket. (See Benefits at a Glance on pages 3-12.) Here is a list of covered home health care services under Plans C-1, C-2, C-3 and C-4:

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

What Is Not Covered

Home health care services that are not covered include but are not limited to:

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



Physical, Occupational, Speech And Vision Therapy

Plan C covers up to 30 days of inpatient physical therapy and rehabilitation per calendar year (in or **out of network** if you are in Plan C-1 or C-2). It also covers up to 50 visits a year in your home, office or at an outpatient facility—but from in-network providers only. In addition, the Plan covers up to an additional 50 visits if medically necessary in the 12 months following a surgical procedure related to the treatment of a neurological disorder. Neurological disorders may include, but are not limited to, amyotrophic lateral sclerosis, cerebral palsy, epilepsy, Parkinson’s disease, muscular dystrophy, multiple sclerosis, spastic paraplegia, and Tourette’s syndrome.

Whether you are enrolled in Plan C-1, C-2, or C-3, the same physical therapy and rehabilitation services are covered. The difference among the Plans is how much you will pay out of pocket. (See Benefits at a Glance starting on page 3.) Physical therapy, physical medicine or rehabilitation services or any combination of these are covered up to the Plan maximums if they are prescribed by a physician, designed to improve or restore physical functioning within a reasonable period of time and approved by Empire’s Medical Management Program. Outpatient care must be given at home, in a therapist’s office or in an outpatient facility by an in-network provider. Inpatient therapy must be short term.

Plan C-4 covers in-patient physical therapy or rehabilitation. It does not cover occupational, speech, or vision therapy.

Occupational, speech or vision therapy or any combination of these are covered on an outpatient basis up to the Plan maximums if:

- prescribed by a physician or in conjunction with a physician’s services
- given by skilled medical personnel at home, in a therapist’s office or in an outpatient facility
- performed by a licensed speech/language pathologist or audiologist, and
- approved by Empire’s Medical Management Program, except vision therapy.

What Is Not Covered

Therapy services that are not covered include but are not limited to:

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



Behavioral Health Care

If you are in Plan C-1 or C-2, outpatient and inpatient treatment for both alcohol or substance abuse and mental health is covered both in-network and out-of-network. If you are in Plan C-3 or C-4, only in-network behavioral health care is covered.

As is true for any medical or surgical inpatient admissions, all inpatient stays for behavioral health care services must be precertified by calling Empire's Member Services at 1-(800) 553-9603. A customer service representative will connect you to a care manager, who can refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

As is true for any medical inpatient admission, when you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call Empire's Member Services at (800) 553-9603 within 48 hours.

Whether you are enrolled in Plan C-1, C-2, C-3, or C-4, the same behavioral health services are covered. The difference among the Plans is how much you will pay out of pocket.

Covered Mental Health Care.

In addition to the services listed in Your Benefits at a Glance section starting on page 3, the following mental health care service is covered:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.

The following mental health care services are not covered:

- Care that is not medically necessary

Covered Treatment for Alcohol or Substance Abuse

In addition to the services listed in Your Benefits at a Glance section starting on page 3, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive medically necessary counseling visits.
- Out-of-network outpatient treatment at a facility that:
 - Has New York State certification from the Office of Alcoholism and Substance Abuse Services, or
 - Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient's diagnosis.

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

- Out-of-network outpatient alcohol or substance abuse treatment at a facility that does not meet Empire's certification requirements as stated above; or
- Care that is not medically necessary

Clinical Trials

You are covered for the routine patient costs for your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if you are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate

All other clinical trials, including when you do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this document.

What's Not Covered

Services that are not covered include but are not limited to:

- the costs of the investigational drugs or devices
- the costs of non-health services required for you to receive the treatment
- the costs of managing the research
- the costs that would not be covered under the Plan for non-investigational treatments provided in the clinical trial

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or

A drug trial that is exempt from having to make an investigational new drug application.

Alcohol and substance abuse treatment services that are not covered include, but are not limited to:

- care that is not medically necessary
- out-of-network services for C-3 and C-4.



Autism/Applied Behavior Analysis (ABA)

The Plan will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of Autism Spectrum Disorder:

- **Screening and Diagnosis.** The Plan will provide coverage for assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.
- **Behavioral Health Treatment.** The Plan Will Provide Coverage For Counseling And Treatment Programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed provider. The Plan will provide such coverage when provided by a licensed provider. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments (over the duration of the intervention) in objective and measurable terms.
- **Applied Behavior Analysis (ABA).** The Plan will provide coverage for Applied Behavior Analysis, when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education.
- **Psychiatric and Psychological Care.** The Plan will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

- **Therapeutic Care.** The Plan will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat Autism Spectrum Disorder and when the services provided by such providers are otherwise covered under this Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Plan.

- **Assistive Communication Devices (ACDs).** The Plan will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, The Plan will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. The Plan will only cover devices that generally are not useful to a person in the absence of a communication impairment. The Plan will not cover items such as, but not limited to, laptops, desktops, or tablet computers. We will cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Plan will determine whether the device should be purchased or rented.

Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per covered device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

The Plan will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

Please refer to the Health Management section starting on page 46 for details regarding precertification requirements.





Services Not Covered

In addition to the services listed under “What Is Not Covered” in each of the preceding sections, the Empire portion of the Plan does not cover the following:

Dental Services

- dental services, including but not limited to:
 - cavities and extractions
 - care of gums
 - bones supporting the teeth or periodontal abscess
 - orthodontia
 - false teeth
 - treatment of a temporomandibular joint and muscle disorder (TMJ) that is dental in nature
 - orthognathic surgery that is dental in nature

Experimental/Investigational Treatments

- technology, treatments, procedures, drugs, biological products or medical devices that in Empire’s judgment are experimental or investigative, or obsolete or ineffective
- any hospitalization in connection with experimental or investigational treatments. “Experimental” or “investigative” means that for the particular diagnosis or treatment of the covered person’s condition, the treatment is not of proven benefit or not generally recognized by the medical community (as reflected in published medical literature).

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

- final market approval by the U.S. Food and Drug Administration (FDA) for the patient’s particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.

- published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes
- published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects)
- published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

However, the Plan will cover an experimental or investigational treatment approved by an External Review agent. The process for External Reviews is described on page 130 of this document.



Gene Therapy

The Fund does not cover any charges for, or related to, gene therapy treatments, whether or not those therapies have received approval from the U.S. Food and Drug Administration (FDA) or whether or not they are considered experimental or investigational, other than Zolgensma, which is covered by the Fund's medical benefits for the treatment of spinal muscular atrophy (SMA) Type 1. For example, this exclusion applies to Chimeric Antigen Receptor T-Cell (CAR-T) therapies such as Kymriah and Yescarta, as well as Luxturna, and to all new gene therapies that become available.

Government Services

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

Home Care

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

Inappropriate Billing

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



Medically Unnecessary Services

- services, treatment or supplies not medically necessary in Empire's judgment. See the glossary for more information.

Prescription Drugs

- all over-the-counter drugs, vitamins, appetite suppressants or any other type of medication, unless specifically indicated

Sterilization/Reproductive Technologies

- reversal of sterilization
- assisted reproductive technologies including but not limited to in-vitro fertilization, intracytoplasmic sperm injection and gamete and zygote intrafallopian tube transfer

Travel

- travel, even if associated with treatment and recommended by a doctor

Vision Care

- eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated for certain medical conditions

War

- services for illness or injury received as a result of war

Workers' Compensation

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

Limitation as Independent Contractor

The relationship between Empire BlueCross BlueShield and hospitals, facilities or providers is that of independent contractors. Nothing in this document shall be deemed to create between Empire and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Neither the Fund nor Empire will be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.



Prescription Drug Benefits

The prescription drug benefit, administered for the Fund by CVS Health, provides coverage for many drugs that require a doctor's prescription, as well as some diabetic supplies that are prescribed by a doctor. You can get prescription drugs two ways under the Plan—from a retail pharmacy or through the CVS Health Mail Service Pharmacy.

Retail Pharmacy

If you are enrolled in Plan C-1 or C-2, you can fill a prescription at an in-network or out-of-network retail pharmacy. You will pay less if you use an in-network pharmacy—and there will be no claim forms to file. If you are enrolled in Plan C-3 or C-4, you can only fill a prescription at a CVS Health network pharmacy.

No Copay for Certain Preventive Care Prescriptions

Prescriptions that are considered preventive under the Affordable Care Act will be covered in full in-network and the above copay schedule will not apply. Contact CVS Health for more information as to whether a particular prescription will be covered in full. Coverage of any preventive medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider. The ACA preventive drug list is subject to change, as ACA guidelines are updated or modified, but currently includes the following:

- Medicine and supplements to prevent certain health conditions for adults, women and children;
- Medicine and products for quitting smoking or chewing tobacco (tobacco cessation);
- Medicine used prior to screenings for certain health conditions in adults;
- Vaccines and immunizations to prevent certain illnesses in infants, children and adults; and
- Generic contraceptives for women. Brand name drugs are payable only if a generic alternative is medically inappropriate

Using an In-Network Pharmacy

When you go to an in-network retail pharmacy, you need to bring your CVS Health ID card and your doctor's written prescription. Your copay depends on whether you:

- are enrolled in Plan C-1, C-2, C-3, or C-4
- fill a short-term or 90-day prescription, and
- fill your prescription with a generic drug, a brand-name drug that does not have a generic equivalent or a brand-name drug that does have a generic equivalent.

COPAYMENTS/COINSURANCE FOR UP TO A 30-DAY SUPPLY AT A CVS HEALTH NETWORK PHARMACY			
DRUG TYPE	PLAN C-1	PLAN C-2/PLAN C-3	PLAN C-4
Generic Drug	\$5	\$5	
Preferred Brand-name drug	20% coinsurance (\$25 minimum/\$40 maximum)	20% coinsurance (\$40 minimum/\$60 maximum)	Deductible and 50% coinsurance
Non-preferred Brand-name drug	40% coinsurance (\$35 minimum/\$50 maximum)	40% coinsurance (\$50 minimum/\$70 maximum)	
Preferred Specialty drug	20% coinsurance (\$25 minimum/\$150 maximum)	20% coinsurance (\$40 minimum/\$150 maximum)	50% coinsurance, with a maximum copayment of \$200 per script
Non-Preferred Specialty drug	40% coinsurance (\$35 minimum/\$150 maximum)	40% coinsurance (\$50 minimum/\$150 maximum)	

*The Plan covers only an initial fill and one refill at a retail pharmacy. See "Mandatory Mail Service" below.

Using a Non-Network Pharmacy

If you are covered under Plan C-1 or C-2 and go to a out-of-network retail pharmacy, you will be required to pay the full cost of your prescription. If you file a claim for reimbursement with CVS Health at the address listed on your claim form, you will be reimbursed for the difference between the pharmacy's charge and the appropriate copay. Claim forms are available from the Fund Office and on the website. Out-of-network prescription claims must be filed within 365 days of the date the prescription was filled. Out-of-network pharmacies are not covered under Plans C-3 or C-4.

Mandatory Mail Service

If you use an in-network retail pharmacy to fill your maintenance prescriptions, the Plan pays benefits only for the initial fill and up to one refill. If your doctor prescribes a "maintenance" medication that you will be taking for an extended period of time (more than 60 days), ask for two prescriptions—one for a 30-day trial that you can fill at an in-network retail pharmacy and the other for a 90-day supply that you can submit to the Mail Service Pharmacy or a local CVS pharmacy.

Mail Service Pharmacy

The CVS Health Mail Service Pharmacy is designed for filling prescriptions for maintenance medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes or asthma. When you fill prescriptions through the Mail Service Pharmacy, you can elect delivery either to your home or an alternate address. (See the next section for instructions on how to fill your initial prescription and order refills through the Mail Service Pharmacy.)

The Mail Service Pharmacy offers both convenience and savings. When you use the Mail Service, you pay a higher copayment than you would pay at a retail pharmacy but you receive up to three times the amount. Your copay for a 90-day supply depends on whether you:

- are enrolled in Plan C-1, C-2, C-3, or C-4, and
- fill your prescription with a generic drug, a brand-name drug that does not have a generic equivalent or a brand-name drug that does have a generic equivalent.

PARTICIPANT COPAYMENTS/COINSURANCE FOR MAINTENANCE MAIL ORDER PRESCRIPTIONS OR FOR UP TO A 90 DAY SUPPLY AT A CVS PHARMACY

DRUG TYPE	PLAN C-1	PLAN C-2/PLAN C-3	PLAN C-4
Generic drug	\$10	\$10	
Preferred Brand-name drug	20% coinsurance (\$60 minimum/\$100 maximum)	20% coinsurance (\$90 minimum/\$140 maximum)	
Non-Preferred Brand-name drug	40% coinsurance (\$100 minimum/\$130 maximum)	40% coinsurance (\$115 minimum/\$175 maximum)	Deductible and 50% coinsurance
Preferred Specialty drugs	20% coinsurance (\$60 minimum/\$300 maximum)	20% coinsurance (\$90 minimum/\$300 maximum)	
Non-Preferred Specialty drugs	40% coinsurance (\$100 minimum/\$300 maximum)	40% coinsurance (\$115 minimum/\$300 maximum)	

Filling Your Initial Prescription through the Mail Service Pharmacy

If your doctor prescribes a maintenance or other long-term medication, follow these steps to fill your initial prescription through the CVS Health Mail Service Pharmacy:

- First, get a 90-day prescription from your doctor with up to three refills (if appropriate).
- Complete the Mail Service order form, which you can fill out and print online at www.caremark.com. Simply log on and click “New Prescriptions.” (Keep in mind that an incomplete form can cause a delay in processing.)
- Mail your order form along with your prescription(s) and payment in an envelope to the CVS Health Mail Service Pharmacy address printed on the form. You can pay using an electronic check, Bill Me Later®, credit card, personal check or money order. You may not send cash.

Your prescription will be delivered within 10 days from the day you submit your order. It will be mailed to your home or an alternate address, whichever you elect.

You also have the option to fill a 90-day prescription at one of 7,000 CVS pharmacies for the same copay as the Mail Service Pharmacy. With this option, you can speak directly with a pharmacist and receive your prescription the same day.

Refilling Prescriptions

You can refill prescriptions by phone, online or at a local CVS pharmacy. To reach CVS Health's automated refill phone service, call (800) 896-1997. To order prescriptions online, you need to register at www.caremark.com. As a registered user, you can also check on the status of your order, look up the cost of your prescription drugs, view your prescription history, find a local in-network pharmacy and contact a pharmacist.

When you log on to register, be prepared to provide your:

- Participant ID number (which appears on the front of your Health ID card)
- date of birth
- credit card number with expiration date, or your Bill Me Later® and electronic check processing information.

Formulary

The Plan utilizes CVS Health's "Standard Control Formulary" and the "Advanced Control Specialty Formulary." Under these CVS Health formularies, specific drugs to treat specific illnesses and diseases may be excluded under the Plan. This means that your doctor may prescribe a specific drug to treat your illness or disease and that drug may not be covered by the Plan, but an alternative prescription may be covered. There is an appeal process if your physician prescribes an excluded formulary drug but there is a medical reason that you may need the drug. If you meet the medical criteria, you will be able to receive the excluded drug.

Specialty Drugs

Specialty drugs are available on an outpatient basis only when ordered through and managed by CVS Health's "Exclusive Specialty Pharmacy." Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis, hepatitis or growth hormone. These drugs may need precertification and often require special handling.

Mandatory Generic

If you are prescribed a brand name prescription drug that has a generic equivalent, you will be asked to switch to the generic drug when you fill the prescription at the pharmacy. If you choose to obtain the brand-name drug rather than the generic equivalent, you will be charged the generic drug copayment and the full difference in cost between the generic drug and the brand-name drug.

If there is a medical reason why you must take the brand-name drug, there is a medical appeals process that would allow your doctor to provide information showing the medical necessity for the brand-name drug.

What Is Covered

The Plan covers the following:

- medically necessary medications that require a doctor's prescription under either federal or state law
- insulin, by prescription only
- insulin syringes and needles, by prescription only
- ACA required preventative drugs.

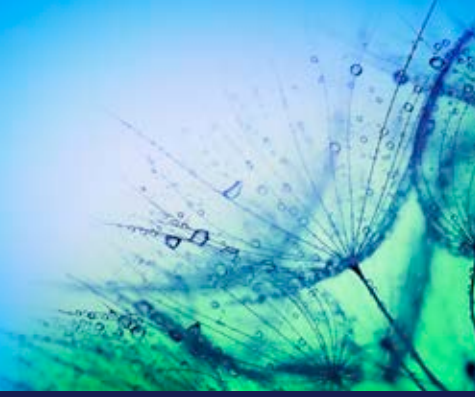
Limitations. Some medications are covered only if your physician provides a diagnosis code for the pharmacy. Certain other medications can be dispensed in no more than specified quantities unless a letter of necessity is provided.

What Is Not Covered

Drugs and supplies that are not covered include, but are not limited to:

- medications, vitamins, supplements, etc. for both adults and children that may be lawfully obtained without a prescription, except that certain over-the-counter substances will be covered in full if they are considered preventive care under the Affordable Care Act
- appliances, devices, support garments, non-medical substances
- administration charges for drugs or insulin
- experimental, investigational or unlabeled use of drugs
- unauthorized refills
- prescriptions covered without charge under federal, state or local programs, including Workers' Compensation
- medications while confined in a rest home, nursing home, extended care facility or similar facility
- medication used for cosmetic purposes (for example, Retin-A for individuals over age 25)
- over-the-counter medicine, unless otherwise specified or required under the ACA preventive care prescriptions
- allergy serums
- anorexiant (diet aids)
- nicotine transdermal systems (except as required under the ACA preventive care prescriptions requirements)
- lupron
- fertility drugs (oral & injectable)
- fluoride dental products (except as required under the ACA preventive care prescriptions requirements)
- imitrex autoinjector & refill vials
- prescription vitamins (except as required under the ACA preventive care prescriptions requirements)
- yohimbine
- ostomy products
- certain restricted medications for which a diagnosis code and/or a letter of necessity was not provided.





Vision Care Benefits

Vision care benefits, provided through Davis Vision, are available under Plans C-1 and Plan C-2. Plans C-3 and C-4 do not provide vision care benefits. Vision care benefits help to pay for routine eye examinations, frames and lenses for you and your covered dependents.

What Is Covered

This section explains how vision benefits are paid when you use Davis Vision in-network providers. Benefits may differ slightly for your covered dependent children, as indicated below.

Exams

You and each covered dependent are entitled to one eye exam from an in-network provider every 24 months. Covered dependent children are eligible every 12 months. No copay is required.

Lenses

You and each covered dependent are entitled to lenses from an in-network provider every 24 months. Covered dependent children are eligible every 12 months. No copay is required for the following types of lenses:

- plastic or glass single vision, bifocal or trifocal lenses, in any prescription range
- intermediate vision lenses
- glass grey #3 prescription lenses
- post cataract lenses
- fashion, sun or gradient tinted plastic lenses
- polycarbonate lenses for dependent children and monocular patients
- ultraviolet (UV coating)
- blended invisible bifocals
- Photogrey Extra® (sun-sensitive) glass lenses
- Scratch-resistant coating

When you purchase lenses, you have the option of adding any of the items listed below at discounted fixed fees, as follows:

- Premier frame from the “Collection”: \$25
- polycarbonate lenses: \$30
- single vision scratch-resistant plan: \$20
- multifocal scratch-resistant plan: \$40
- standard ARC (anti-reflective coating): \$35
- premium ARC (anti-reflective coating): \$48
- polarized lenses: \$75
- plastic photosensitive lenses: \$65
- high-index (thinner and lighter) lenses: \$55
- standard progressive addition lenses: \$50
- premium progressive addition lenses: \$90
- ultra progressive additional multi-focal lenses: \$140
- (For all progressives, while these lenses can be worn by most people, conventional bifocals will be supplied to anyone who is unable to adapt to progressive addition lenses; the copay, however, will not be refunded.)



Frames

You and each covered dependent are entitled to a frame from the Fashion and Designer Collection every 24 months. No copay is required. Frames from the Premier Collection are also available for a \$25 copay. Alternatively, if you choose an in-network provider’s own frame, you will receive a \$45 allowance toward the cost of the frame.

Contact Lenses

You and each covered dependent are entitled to contact lenses every 24 months. No copay is required for the following:

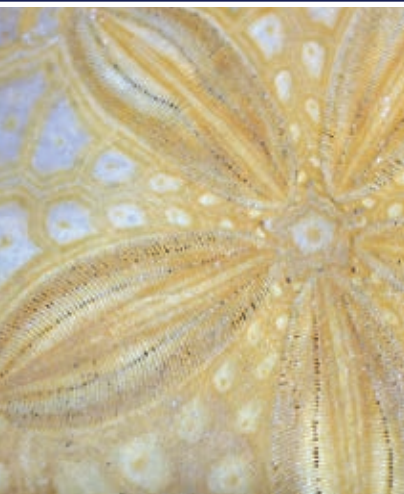
- standard, soft, daily-wear or disposable lenses (four multi-packs)
- planned replacement contact lenses (two multi-packs)
- As an alternative, you may receive a \$105 credit plus a 15% discount toward contact lenses from the provider’s own supply. Medically necessary contact lenses are covered in full with prior approval.

Mail Order Contact Lenses:

Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member website for details.

Low Vision Services

You and each covered dependent are entitled to a comprehensive low vision evaluation once every five years.



Receiving Services from an In-Network Provider

Call the provider to schedule an appointment and identify yourself as a participant (or covered dependent) in the IATSE National Health & Welfare Fund. Provide the member's ID number and the year of birth of any covered dependent children needing services. The provider will verify your eligibility for services. No claim forms or ID cards are required.

If You Use an Out-of-Network Provider

If you choose to use a provider that is not part of the Davis Vision network, you are eligible for reimbursement up to \$100 every 24 months (every 12 months for dependent children). This amount is for all services and products combined and is not available in addition to in-network benefits. In addition, the Plan will cover the cost of annual exams for children through age 18 up to the in-network reimbursement amount applicable to that provider in that geographic area. For medically necessary contact lenses, you may be reimbursed for up to \$225 with prior approval.

If you receive services from an out-of-network provider, you are responsible for paying the provider directly in full and then submitting a claim form for reimbursement (available at www.davisvision.com) to:

Vision Care Processing Unit
P.O. Box 1525
Latham, New York 12110

You have 18 months from the date of service to file an out-of-network claim.

What Is Not Covered

Vision services and products that are not covered by this program include but are not limited to:

- medical treatment of eye disease or injury (although this may be covered as part of your Empire BlueCross BlueShield medical benefits)
- vision therapy
- special lens designs or coatings
- replacement of lost eyewear
- non-prescription (plano) lenses
- services not performed by licensed personnel
- two pairs of eyeglasses in lieu of bifocals
- contact lenses and eyeglasses in the same benefit cycle.

May I use the benefit at different times?

You may “split” your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either an in-network or an out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

For more information, please visit Davis Vision’s website at www.davisvision.com or call Davis Vision at 1.800.999.5431 to:

- Learn more about your benefits
- Locate a Davis Vision provider
- Verify eligibility
- Print an enrollment confirmation
- Request an out-of-network provider reimbursement form

Contact a Member Service Representative Member Service Representatives are available:

- Monday through Friday, 8:00 AM to 11:00 PM, Eastern Time • Saturday, 9:00 AM to 4:00 PM, Eastern Time • Sunday, 12:00 PM to 4:00 PM, Eastern Time

Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.





Dental Benefits

Dental benefits, provided through Delta Dental, are available under Plans C-1, C-2 and C-3. Plans C-1 and C-2 provide comprehensive dental coverage. Plan C-3, however, covers only basic preventive care. Plan C-4 does not cover dental services.

If you live in New York State, you may choose dental coverage through Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS) instead of Delta Dental. For more information about ASO/SIDS coverage, call ASO/SIDS at (800) 537-1238.

The Plan's dental benefit provides up to \$2,000 per covered person, per calendar year. The \$2,000 limit does not apply to diagnostic and preventive services for dependents under age 19. There is no annual deductible to meet before the Plan pays benefits, and you have the freedom to visit any licensed dentist. The benefit for any particular procedure is determined by a set fee schedule. The amount you pay is determined by how much your dentist charges or has agreed to accept from Delta Dental, whichever is less.

Delta Dental offers two networks of dentists—Delta Dental PPO and Delta Dental Premier. Regardless of which network you use, the Plan will pay the amount shown in the current schedule of allowances. Your cost will depend on which network you use or whether you choose to go **out of network** entirely. You will likely save:

- most if you go to a Delta Dental PPO dentist
- some if you go to a Delta Dental premier dentist
- least if you go to an out-of-network dentist.

To find a Delta Dental PPO dentist or a Delta Dental Premier® dentist, call (800) 932-0783 or log on to www.deltadentalins.com/iatse.

Eligible Expenses

In order to qualify for reimbursement, an expense must:

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

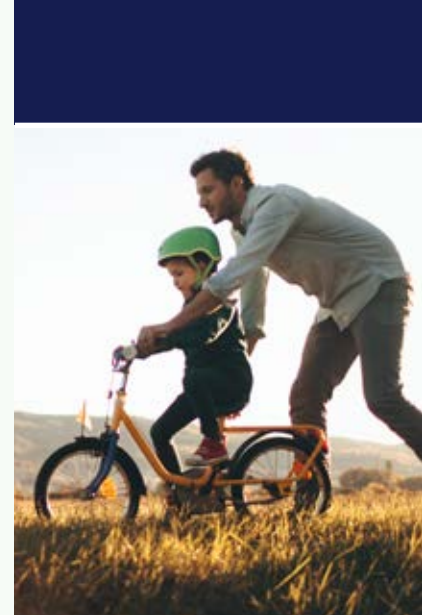
How Much You Will Pay

The Fund pays a fixed allowance for each covered service as listed in the Schedule of Dental Benefits. You can request a copy of the Fund’s Schedule of Dental Benefits by calling Delta Dental. There will be no charge to you to receive a copy of the Schedule. You pay for the portion of the dentist’s fee that exceeds the allowance (plus any amount over the annual maximum and the full amount for any services not covered by your Plan).

You can visit a Delta Dental PPO in-network dentist, a Delta Dental Premier in-network dentist or a dentist who is not in either network. However, there are advantages to using a PPO dentist instead of a Premier or out-of-network dentist. Since PPO dentists agree to accept fees that are significantly reduced, you will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist. If you cannot visit a PPO in-network dentist, a Premier in-network dentist (who also agrees to reduced fees) may still save you money. With either network, you will be responsible for the difference between the Plan allowance and the reduced fee that has been approved by Delta Dental. If you use an out-of-network dentist, you will be responsible for the difference between the Plan allowance and the dentist’s full charge.

Example. Here is a comparison of how much you would pay a PPO dentist, a Premier dentist and an out-of-network dentist for a crown that costs \$2,000 unreduced. (Note: Crowns and other major restorative services are not covered under Plan C-3 and C-4, as these plans do not cover any dental services.)

	DELTA DENTAL PPO	DELTA DENTAL PREMIER	OUT-OF- NETWORK
Fee for procedure (crown)	\$2,000	\$2,000	\$2,000
Amount approved by Delta Dental	\$745	\$1,450	N/A
How much the Plan pays (from Schedule of Dental Benefits)	\$400	\$400	\$400
How much you pay	\$345 (\$745–\$400)	\$1,050 (\$1,450–\$400)	\$1,600 (\$2,000–\$400)



What Is Covered

The Schedule of Dental Benefits, available from Delta Dental at no charge upon request, provides a complete list of covered dental services. What services are covered will be determined based on the Plan rules and dental necessity. You, or your dentist, can contact Delta Dental to determine in advance whether a procedure will be covered and the amount of the Fund's allowance for that procedure. Please see the "Predetermination of Benefits" section below. The Fund will pay for pediatric (children under age 19) Diagnostic, Preventive and Basic Services at the Delta Dental PPO reimbursement rate, if that rate is higher than the Schedule of Dental Benefits. In general, though, Plans C-1, C-2 and C-3 cover the following diagnostic and preventive services:

- oral examination, twice per calendar year
- prophylaxis (teeth cleaning), twice per calendar year
- x-rays, subject to annual x-ray maximum
- fluoride treatment for children (up to age 19), twice per calendar year
- sealant for children (up to age 19), for posterior permanent teeth, maximum once per calendar year.

In addition, Plans C-1 and C-2 cover additional services, such as:

- amalgam and composite fillings
- inlays, onlays and crowns
- oral surgery, including extractions and other surgical procedures
- endodontic treatment, including root canal therapy
- non-surgical and surgical periodontics (treatment of gum and bones)
- prosthodontics, including dentures and bridges
- injectable antibiotics
- occlusal guards and adjustments.

Orthodontic services are not covered under the Plan.

Predetermination of Benefits

Predetermination enables you and your dentist to know in advance how much the Plan will pay for any service that may be in question. A predetermination is recommended if total charges are expected to exceed \$300. However, it is not mandatory, and claims for benefits will not be denied if a predetermination is not filed.

To take advantage of predetermination, your dentist submits a claim form before performing services. Delta Dental will return the predetermination voucher to your dentist (with a copy to you) explaining eligibility, scope of benefits and the period of time for completion of services.

Note. You should keep in mind that a pretreatment review estimate is not a promise of payment. The work must be done while the patient is still covered by the Plan, unless there is an "extension of benefits."

An extension of benefits is granted only if the service was:

- for crowns, fixed bridgework or full or partial dentures, and a pretreatment authorization was granted, impressions were taken and/or teeth were prepared while the patient was covered, and the device was installed or delivered within one month after that person's coverage ended.
- for root canal therapy, and the pulp chamber of the tooth was opened while the patient was covered and the treatment was completed within one month after that person's coverage ended.

Alternate Procedures

In some cases, there is more than one way to treat a dental problem. When you submit a request for pretreatment review, the Plan will consider alternate procedures and may authorize an amount of reimbursement based on an alternate procedure (which may differ from the one proposed by your dentist) that will provide a professionally acceptable result in a cost-effective manner. In such a case, if you choose to go ahead with the original treatment plan, reimbursement will be based on the alternate course of treatment, and you will be responsible for paying any difference. This should in no way be considered a reflection on your treating dentist's recommendations. Payment for an alternate course of treatment is a benefit determination and not a treatment plan designation.

What Is Not Covered

The Plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The Plan does not provide benefits for:

1. Surgical procedures including but not limited to reduction of fractures, removal of tumors and removal of impacted teeth are subject to the provisions described in the Other Health Insurance section of this booklet.
2. Treatment or materials with respect to skeletal malformation, except for treatment due to accidental injury to sound natural teeth within 12 months of the accident or treatment necessary due to congenital disease or anomaly, or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not apply to covered dependent children or eligible newborn children so long as such dependent children continue to be eligible. When services are not excluded under this provision as to these dependent children who continue to be eligible, other limitations and exclusions of this section shall specifically apply.
3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and except for reconstructive surgery necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.
5. Treatment or materials for which the enrollee would have no legal obligation to pay.
6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Myofunctional therapy, unless covered by the exception in Item 2, above.
10. Temporomandibular joint dysfunction treatment that is medical in nature.
11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
12. Implants and related services, unless covered by the exception Item 2, above.
13. Experimental procedures that have not been accepted by the American Dental Association.
14. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.

15. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
16. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
17. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
18. Services not included on the Table of Allowances.
19. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered benefit.

LIMITATIONS

Benefits to enrollees are limited as follows:

- Limitation on Optional Treatment Plan. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.
- Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the amount of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.
- Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the enrollee.
- Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section "What is Covered" on page 106. Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.
- Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the enrollee.
- Limitation on Sealants. Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.
- Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

The following expenses are not covered under the Plan:

1. treatment solely for the purpose of cosmetic improvement
2. replacement of a lost or stolen appliance
3. replacement of a bridge, crown or denture within five years after it was originally installed; replacement of a bridge, crown or denture that is or can be made usable according to common dental standards
4. orthodontic services
5. procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) reposition teeth by orthodontic means
6. multiple bridge abutments
7. a surgical implant of any type
8. services that do not meet common dental standards
9. services not included in the Schedule of Dental Benefits
10. work-related injury
11. an accidental injury that is the responsibility of a third party
12. a condition covered by Workers' Compensation or a similar law for which the patient is eligible to receive coverage
13. treatment in a hospital owned or run by the U.S. government, unless there is a legal obligation to pay those charges whether or not there is any insurance
14. care for which charges would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family
15. unnecessary care, treatment or surgery
16. experimental procedures or treatment methods
17. treatment for which payment is unlawful where the patient lives when the expenses are incurred
18. treatment for which payment is available through a public program

Questions? Contact Delta Dental Member Services at (800) 932-0783 or log on to www.deltadentalins.com/iatse.

Filing a Claim for Dental Benefits

Both Delta Dental PPO and Premier dentists submit claims for payment to Delta Dental. You do not have to submit any forms. However, if you visit an out-of-network dentist, you may have to pay the fee at the time of your visit and send in a claim form for reimbursement. Claim forms are available online at www.iatsenbf.org. Send the completed form to Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-2105. Dental claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.

Do not forget that the Plan never pays more than 100% of the allowance listed on the Schedule of Dental Benefits. If you go to an out-of-network dentist who charges more, you will be responsible for the difference.



Physical Exams And Hearing Aid Benefits

Two additional health care benefits are provided under Plans C-1 and C-2. Plans C-3 and C-4 do not provide these benefits.

Out-of-Network Physical Exam

You may be reimbursed up to \$300 each calendar year for a complete annual physical and any related tests for each covered individual, as long as services are rendered by out-of-network providers.

Hearing Aid

You may be reimbursed up to \$1,500 in a 36-month period for a hearing aid and/or batteries or repairs.

Claiming the Benefits

A claim form is available online at www.iatsenbf.org. Fill it out and attach a detailed itemized statement for each expense that you have incurred and any explanation of benefit statements you have received from other insurance you may have. Send the completed form and documentation to ASO/SIDS, P.O. Box 9005, Dept. 7, Lynbrook, NY 11563-9005.



Life Insurance Benefits

A life insurance benefit, provided through MetLife, is available under Plans C-1, Plan C-2, Plan C-3 or Plan C-4. This benefit pays a lump sum to your survivors in the event of your death, from any cause, while you are covered under Plan C-1, Plan C-2, Plan C-3 or Plan C-4.

If you die while enrolled in Plan C-1 or C-2, your designated beneficiary or beneficiaries will receive a \$20,000 life insurance benefit. If you die while enrolled in Plan C-3 or C-4, your designated beneficiary or beneficiaries will receive a \$10,000 life insurance benefit. MetLife has the right to pay up to \$500 of the \$20,000 or \$10,000 life insurance proceeds to a person it determines has incurred funeral or other expenses related to your last illness or death.

Naming a Beneficiary

When you enroll for medical coverage under Plan C, you will be asked to fill out a life insurance beneficiary designation form. The beneficiary you name for this insurance is not automatically your beneficiary under any of the other National Benefit Funds in which you may participate. Nor is your beneficiary under one of those plans automatically your beneficiary under this Plan. Each Fund has its own rules, procedures and forms regarding the designation of beneficiaries.

You may name any person or persons you wish, subject to the following rules:

- If two (2) or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.
- If there is no designated beneficiary, or if no designated beneficiary is living after the insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters (including half-siblings). If no class has a survivor, the beneficiary is your estate.
- When a beneficiary dies before you, that person's interest in your life insurance benefit automatically ends.
- In the event a beneficiary is a child, is mentally incapacitated or is otherwise unable to manage his or her affairs, and no legal guardian has been appointed, the Plan may pay any amount due to the party it believes is entitled to receive it on behalf of that individual.



- You may change your beneficiary designation at any time by completing a new beneficiary designation form (available online at www.iatsenbf.org) and sending it to the Fund Office. The change will be effective when the Fund Office receives the new form. You do not need anyone's consent to change your beneficiary designation.
- Designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Fund Office and received before your death will not be effective.

You should review your beneficiary designations for all Funds in which you participate every year to make sure your choices are up to date. To change your beneficiary for the life insurance benefit under the Health & Welfare Fund Plan C, you need to complete and return a new beneficiary designation form (available online at www.iatsenbf.org) to the Fund Office. Your change will not be effective until the Fund Office receives the form.

Consider your beneficiary designations and coverage elections under all your benefit plans if you have a change in family status, such as a marriage, separation, divorce, death or the birth or adoption of a child. Contact the Fund Office if you have any questions about the effect of these events under the National Benefit Funds.

Filing a Claim for Benefits

Information on this life insurance, as well as required forms and supporting documentation, are available from the Fund Office.

Questions? If you have any questions about the life insurance benefit, contact the Fund Office at (212) 580-9092 in New York or (800) 456-FUND (3863) outside New York. For questions about a life insurance claim that has already been submitted to MetLife, please call MetLife Group Claims at 1-800-638-6420, then press 2.



Retiree Health Benefit Plan

If you meet the requirements for retiree coverage, you will be entitled to the special retiree benefits described in this section.

Eligibility

You are entitled to retiree benefits if:

- your retirement started on or after January 1, 2001, at age 65 or older
- you are on Medicare
- you completed 15 calendar **years of service** under the Health & Welfare Fund
- four of your years of service under the Health & Welfare Fund were during the five calendar years immediately before you retired at age 65 or older.

In the case of certain plans that were merged into this Plan, the merger agreement may provide for other benefits or the recognition of service or retiree status under the merged plan. Further, under some merger agreements certain groups of retirees may have to pay an additional amount for the benefits described in this section. If you have any questions about these rules, contact the Fund Office.

Enrollment

If you meet the eligibility requirements for retiree health benefits when you reach age 65, you will receive an application for coverage from the Fund Office. You will certify on the application that you are no longer working in covered employment. You must sign the application and return it to the Fund Office along with a copy of your retirement check or other verification of retiree status and a copy of your Medicare card.

If you return to work for an employer that contributes to the IATSE National Health & Welfare Fund and contributions made on your behalf equal at least one quarter of Plan C-4 single coverage (or you qualify for coverage under Plan A), your retiree health benefits will be suspended. They can begin again only after you stop working and submit another application for retiree benefits. Please call the Fund Office if you return to work and/or need an application.



What the Benefit Is

If you meet the requirements described above, you will be entitled to:

- \$75 per quarter reimbursement toward the cost of the Medicare Part B premium
- up to \$246 per quarter reimbursement toward the cost of your “Medigap” health care premium (proof of payment will be required)
- up to \$500 per calendar year reimbursement toward the cost of your Medicare Part D (prescription drug) premium
- an optical benefit that consists of one pair of glasses and one exam in a 24-month period
- a hearing aid benefit that will reimburse you up to \$1,500 in a 36-month period.

Spouse Coverage

Your spouse is also entitled to these benefits if he or she is on Medicare. (The Fund Office will require a copy of the Medicare card as proof of coverage.)

If you die after your retiree coverage begins, your spouse’s coverage will continue for one year. If your spouse dies or you divorce and you remarry, your new spouse will be eligible for coverage, provided that you enroll the new spouse with the Fund.

Medicare Benefits

Medicare consists of four parts:

- Part A provides hospital benefits and is available to most people at no cost.
- Part B provides medical benefits and requires that you pay a monthly premium.
- Part C, also known as Medicare Advantage, refers to plans such as HMOs and PPOs that are offered by private insurance companies as alternatives to Parts A and B. They provide hospital and medical benefits, and many also provide prescription drug benefits. Part C plans require that you pay a monthly premium.
- Part D is prescription drug option run by a private insurance company. It requires that you pay a monthly premium.

Applying for Medicare

Be sure to contact the Social Security Administration at least three months before you reach age 65 to sign up for both Medicare and Social Security benefits. You can file your application by telephone by calling (800) MEDICARE (800-633-4227) or in person at a local Social Security office. For more information or to find an office near you, visit www.medicare.gov.

How to Claim Benefits

For Medicare Part B premium reimbursement, when you first become eligible for retiree benefits, you will be required to provide:

- a copy of your Medicare card
- if your spouse is on Medicare, a copy of his or her Medicare card and your marriage certificate.

For Medigap premium reimbursement, you are required to submit the following every quarter:

- a copy of your insurance premium notice, with your full name and Social Security number included
- a copy of your canceled check.

For Part D premium reimbursement, you are required to submit a Medicare statement showing the amount you have paid or that is being deducted from your Social Security benefit.

For all other retiree benefits, claims are administered in the same way as for active members, specifically:

- vision care benefits are provided through Davis Vision
- the hearing aid benefit is provided through ASO/SIDS.

For more information on filing vision care and hearing aid benefits, please refer to the appropriate sections of this SPD.

Continuation of Benefits

Like other Fund benefits, retiree benefits are subject to change or termination at any time at the sole and absolute discretion of the Board of Trustees.





Coordination Of Benefits

Our Plan has a coordination of benefits (COB) provision. This provision ensures that if you or a covered dependent is covered by another group health plan, benefits from all plans combined will not exceed:

- 100% of the maximum allowed amount in the case of Empire BlueCross BlueShield hospital and medical benefits
- 100% of the maximum amount payable for a procedure on our Plan's Schedule of Dental Benefits
- 100% of the maximum allowable expense in the case of any other benefit.

Other Group Medical Plans

Members of a family often have more than one group medical plan, particularly if both spouses are working. For this purpose, "group medical plan" generally means a plan that provides medical benefits through:

- group insurance
- group BlueCross, group BlueShield, group practice or other prepayment coverage on a group basis
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans
- coverage under governmental programs or coverage required or provided by any statute
- school or association plans.

Which Plan Pays First

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Here is how the Plan determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are a participant in the Health & Welfare Fund and a dependent under the other plan, the Health & Welfare Fund Plan C is primary.

- For a dependent child covered under both parents' plans, the primary plan is determined as follows:
 - The plan of the parent whose birthday comes earlier in the calendar year (month and day) is primary.
 - The plan that has covered the parent for a longer period of time is primary, if the parents have the same birthday.
 - The father's plan is primary, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility.
 - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's health care expenses), the plan covering the parent with custody is primary.
 - If the parent with custody is remarried, his or her plan pays first, the stepparent's plan pays second, and the non-custodial parent's plan pays third.
 - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's health care expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules applies, the plan that has covered the patient longest is primary.



Tips for Coordinating Benefits: To receive all the benefits available to you, file your claim under each plan. File claims first with the primary plan, then with the secondary plan. Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

To administer COB, the Plan reserves the right to:

- a) exchange information with other plans involved in paying claims;
- b) require that you or your Health Care Provider furnish any necessary information;
- c) reimburse any plan that made payments this Plan should have made; or
- d) recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.



If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's allowed charge.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Medicare

Different COB rules apply for active employees and spouses of active employees covered by our Plan who are also Medicare eligible. This Plan always pays first unless you or your spouse rejects this coverage and chooses Medicare as primary coverage, which means Medicare pays first. However, if you or your spouse does this, the Plan will not pay any difference between the benefits paid by Medicare and the amount that is actually charged. In other words, you will be waiving coverage under this Plan, which means you will have no coverage for expenses that are covered by this Plan, but not by Medicare.

For disabled participants and disabled covered dependents of active participants who are under age 65 but are also eligible for Medicare, this Plan pays first until age 65. This Plan also pays first during the first 30 months of end-stage renal disease.



Claims And Appeals Procedures

This section describes the procedures for filing claims for benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision.

If you are covered by Triple-S PPO, the procedures for filing hospital, medical and prescription drug claims and internal appeals may be different and are described in materials from Triple-S. External appeals procedures are the same and are described beginning on page 130.

Terms You Should Know

- Adverse determination (i) a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; (ii) 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 (iii) a rescission of coverage, whether or not there is an adverse effect on any particular benefit.
- Days: For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.
- A health care professional, for the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including filing a claim (where necessary). In addition, a specific request for eligibility relating to a particular person and period shall be treated as an eligibility claim under these procedures. The claims procedures vary depending on the specific benefit you are requesting.

If your claim for benefits is denied, in whole or in part, you may be able to appeal that decision. How to appeal depends on what type of claim was denied.



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

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail 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 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 verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
 - A request for prior approval where prior approval is not required by the Plan;
 - A general eligibility inquiry. 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 or which relate to proposed or anticipated treatment or services that do not require prior approval.

Where and How to File Claims

Hospital and Medical Benefits

Empire makes health care easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO network, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received out of network or if you have a medical emergency out of the Empire service area. A claim form is available online at www.iatsenbf.org or from the Fund Office.

Send completed hospital claims to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attn: Institutional Claims Department

Send completed medical claims to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attn: Medical Claims Department

Triple S

If you are enrolled in the Triple-S PPO, there may be situations in which you need to make a claim for reimbursement. To make a claim, send the original payment receipt to:

Triple-S, Inc.
Reimbursement Section
Box 363628
San Juan, PR 00936-3628

Prescription Drug Benefits

Most prescriptions are filled directly by an in-network pharmacist. However, the presentation of a prescription to a pharmacist does not constitute a claim. If an in-network pharmacist rejects your prescription request, in whole or in part, you may submit the prescription, with a completed claim form (available online at www.iatsenbf.org or from the Fund Office) to CVS Health at the address on the form. Also, if you purchased covered medication from a non-network pharmacist or without your CVS Health card, you may submit the paid receipt for the prescription with a claim form.

Vision Care Benefits

A claim form for out-of-network vision care services is available at www.davisvision.com. Send the completed form to:

Vision Care Processing Unit
P.O. Box 1525
Latham, New York 12110

DENTAL BENEFITS

A claim form for out-of-network dental services is available online at www.iatsenbf.org or from the Fund Office.

For Delta Dental, send the completed form to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-2105

For ASO/SIDS, send the completed form to:

ASO/SIDS
P.O. Box 9005, Dept. 7
Lynbrook, NY 11563-9005

PHYSICAL EXAM OR HEARING AID BENEFITS

A claim form for an annual physical examination or hearing aid is available online at www.iatsenbf.org or from the Fund Office. Send the completed form to:

ASO/SIDS
P.O. Box 9005, Dept. 7
Lynbrook, NY 11563-9005

PLAN C-MRP (MEDICAL REIMBURSEMENT PROGRAM)

How you file your claim depends on which type of claim you are making — for a health care insurance premium or for an expense that is not covered in full under your health care coverage. Claim forms are available on the Fund's website, www.iatsenbf.org, or can be obtained by requesting one through the Participant Services Center. You can easily reach the center by e-mail at pssc@iatsenbf.org or by calling it Monday through Friday, 8:30 am to 5:00 pm EST, at (800) 456-FUND (3863) or (212) 580-9092 in New York. When submitting a claim, please make sure you complete all information on the form, sign the certification, and attach all required documentation, whether you are uploading it through the website or are mailing it to us, so there is no delay in the processing of your claims. Send the completed form to:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
(212) 580-9092 in New York
(800) 456-FUND (3863) outside New York

You can also submit your claims using the Fund's website, www.iatsenbf.org, by uploading your claim(s) and the appropriate required documentation, such as your other health plan's EOB (explanation of benefits), an itemized bill, proof of post-tax payment for other employer or union sponsored group health coverage, etc. You can also use the website to view the status of your claim and to view the balance of your CAPP/ retiree MRP account available for reimbursements. You must sign and date your claim form, including the certification that the claims meet all guidelines of Plan C-MRP, to receive a reimbursement.

LIFE INSURANCE BENEFITS OR ELIGIBILITY

Contact the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
(212) 580-9092 in New York
(800) 456-FUND (3863) outside New York

RETIREE HEALTH PLAN BENEFITS

Contact the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
(212) 580-9092 in New York
(800) 456-FUND (3863) outside New York

When Claims Must Be Filed

Medical claims must be filed within 18 months following the date the charges were incurred. Dental claims must be filed within 12 months after the date of service. Plan C-MRP claims must be filed within twelve months of the date on which the earliest claim was incurred. A life insurance claim must be filed within 18 months of the date of death. Prescription claims must be filed within 365 days of the date the prescription was filled. Vision claims must be filed within 18 months of the date of service. Eligibility claims must be filed within 90 days of the start of the period for which you are claiming coverage. Retiree Health Plan claims or claims for physical exam or hearing aid benefits must be filed within 12 months of the date of service or, for premium reimbursement, within 12 months of the date such coverage started.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you have previously designated the individual to act on your behalf. If you wish to designate an authorized representative to file claims on your behalf, you must contact the specific health organization that provides the benefit to you. The health organization will inform you of the procedure to follow in designating your authorized representative. The health organization may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined on the next page) without you having to complete the special authorization form.

Claims Procedures

The claims procedures for health benefits (hospital, medical, dental, vision, prescription drug, physical exam and hearing aid benefits and medical reimbursement) will vary depending on whether you are making a preservice claim, an urgent care claim, a concurrent care claim or a post service claim. The procedures for life insurance claims also vary. Empire's procedures are described beginning on page 51. The procedures for other providers are described below.

Other Claims Filing Rules

You must be enrolled in the Plan both on the date of the service for which you are seeking reimbursement and at the time you submit a claim to receive reimbursement. Similarly, any spouse or dependent must be enrolled in the Plan both on the date of service and at the time you submit the claim.

If you are enrolled in single coverage under one of the Plan C-options offered by the Fund and have excess funds in your CAPP account, you can submit claims incurred by your spouse and/or dependents to Plan C-MRP. However, as of January 1, 2017, you will only be eligible to receive a reimbursement from Plan C-MRP for your spouse or dependent's claim if on the date of service such individual was covered by an employer or union sponsored **group** medical plan that meets the minimum value standard of the ACA. You will be required to sign a certification of this at the time you submit the claim. (This requirement does not apply to reimbursement of spouse and dependent claims from Plan R-MRP.)

Preservice Claims

A preservice claim is a claim for a benefit that requires approval (in whole or in part) before medical care is obtained. Refer to the specific benefits for details on what services require prior approval.

If you improperly file a preservice claim, the health organization will notify you as soon as possible, but no later than five days after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the health organization and it includes your name, your specific medical condition or symptom and a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed preservice claims, you and your health care provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the health organization. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the health organization needs additional information from you, the extension notice will specify the information needed. In that case, you and/or your doctor will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The health organization then has 15 days (from the date it receives your response) to make a decision and notify you of the determination. You have the right to appeal a denial of your pre-service claim. (See Review Process and Timing of Notice of Decision on Appeal on pages 127 and 128.)

Urgent Care Claims

An urgent care claim is any preservice claim for medical, dental or prescription care or treatment with respect to which the application of the time periods for making preservice claim determinations:

- could seriously jeopardize your life or health or your ability to regain maximum function, or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Whether your claim is an urgent care claim is determined by the health organization, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning described above shall be treated as an urgent care claim.

If you improperly file an urgent care claim, the health organization will notify you as soon as possible, but no later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the health organization and it includes your name, your specific medical condition or symptom and a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed urgent care claims, the health organization will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the health organization. The determination will also be confirmed in writing.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the health organization will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You will then have a period of no less than 48 hours, taking into account the circumstances, to provide the specified information to the health organization. The health organization will then notify you of the benefit determination no later than 48 hours after the earlier of the health organization's receipt of the specified information or the end of the period afforded to you to provide the specified additional information.

Concurrent Claims

A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if five days are still appropriate.) In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

If you are receiving concurrent care benefits and the health organization decides to reduce or terminate the course of treatment before the end of the previously approved treatment period (other than by Plan amendment or termination), you will be notified of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you ample time to request a review of the decision and obtain a determination upon review before the benefit is reduced or terminated.

If you make a claim to extend a course of treatment beyond the approved period of time or number of treatments, and the claim involves urgent care, the health organization will make a determination on your claim as soon as possible, taking into account medical exigencies, and will notify you of the decision within 24 hours after receipt of your claim, provided that your claim was filed at least 24 hours before expiration of the previously approved period of time or number of treatments.

Post-Service Claims

Ordinarily, you will be notified of the decision on your post-service claim within 30 days from receipt of the claim by the health organization. This period may be extended one time by the health organization for up to 15 days if the extension is necessary due to matters beyond the control of the health organization. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the health organization expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The health organization then has 15 days from the date it receives the requested information to make a decision on a post-service claim and notify you of the determination.

Life Insurance Claims

A life insurance claim is a claim made by your beneficiary on the occasion of your death. Claim forms and instructions for completing the form may be obtained from the Fund Office. All claim forms must be completed in accordance with the instructions and mailed to the Fund Office. The Fund Office will forward the claim to MetLife for processing. The claim form should be completed by the beneficiary, or if there is no named or surviving beneficiary, then by the surviving family member(s) entitled to the benefit (see page 111). If the individual entitled to the benefit is a minor, the claim form should be completed and signed by Guardian of the Property of such minor and certified guardianship papers should also be submitted. If the benefit is payable to the estate, then the claim form should be completed by the executor.

Once the Fund Office receives the claim and forwards it to MetLife, MetLife will notify the beneficiary that the claim has been received and is being reviewed. The beneficiary will be instructed to call the MetLife Claims Department at (800) 250-8898 for any questions.

MetLife will make a decision on the claim and notify your beneficiary within 90 days of its receipt of the completed claim form and all required documentation. If MetLife requires an extension of time due to matters beyond its control, it will notify your beneficiary of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time MetLife notifies your beneficiary of the delay. If an extension is needed because additional information is needed from your beneficiary, the extension notice will specify the information needed. Until your beneficiary supplies this additional information, the normal period for making a decision on the claim will be suspended.

Eligibility Claims

Submit claims for eligibility under the Plan directly to the Fund Office. You do not have to fill out any claim forms to make an eligibility claim. However, you must provide the Fund Office with a written description of the circumstances surrounding your claim so that your claim can be adjudicated properly.

The Fund Office will make a decision on the claim and notify you or your beneficiary within 90 days. If the Fund Office requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Fund Office notifies you of the delay. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Notice of Decision

If the Claims Administrator denies your initial claim, in whole or in part, you will be given 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 include:

- the identity of the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- 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 [or external review]);
- a description of the Plan’s standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits about how to initiate an internal and an external appeal
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

If the determination was based on the absence of medical necessity, because the treatment was experimental or investigational or subject to another similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. For urgent care claims, the required determination may be provided orally and followed with written notification.

For all preservice claims (including urgent care claims), you will receive notice of the determination even when the claim is approved.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if any adverse benefit determination is made with respect to your claim, you may ask for a review, that is, an “appeal.”

Appeals are made to the specific health organization that processed the claim, except for appeals of eligibility claims, which are made to the Fund Office for review by the Board of Trustees of the Fund.

The name, address and telephone number of the Fund Office and of all the health organizations that service the Plan are listed earlier in this section. However, appeals of hospital or medical claims denied by Empire (including requests for External Reviews), should be sent to the following address:

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

Your request for review must be made in writing within 180 days after you receive notice of denial for all claims except life insurance and eligibility. Appeals regarding life insurance and eligibility claims must be made within 60 days.

Review Process

The review process works as follows:

- You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office or health organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the benefit determination); it demonstrates compliance with the Fund Office's or health organization's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.
- You will have the opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits.
- You have the right to 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;
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office or health organization on your claim, without regard to whether their advice was relied upon in deciding your claim.
- The review will not afford deference to the initial adverse benefit determination. Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will be 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. 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.
- You will also be provided free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on review is denied based on a new or additional rationale, you will receive the rationale, free of charge. 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 a 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.

Timing of Notice of Decision on Appeal

Preservice Claims. Empire BlueCross BlueShield offers two levels of appeal for preservice claims. Each level of appeal will be decided within 15 days. If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be filed within 180 days of your receipt of the decision regarding the first appeal. All decisions will be in writing.

All other preservice appeals are to be directed to the entity that provided the service, which will provide one level of appeal. This appeal will be decided within 30 days. You will receive a written notice from the applicable entity indicating its decision.

Urgent Care Claims

Urgent care appeals will be decided within 72 hours of their receipt. You will receive verbal notice of the decision, followed by written notification.

Concurrent Claims

Concurrent appeals will be decided within 24 hours, provided the appeal was received 24 hours before the care ends. All concurrent appeals that involve a reduction or termination of treatment that had previously been approved will be decided before the treatment ends. All other concurrent appeals will be decided using the preservice appeals procedures above.

Post-Service Medical, Hospital, Prescription Drug, Dental and Vision Claims

Empire BlueCross BlueShield, CVS Health, Delta Dental, ASO/SIDS and Davis Vision offer two levels of appeal for post-service claims. Each level of appeal will be decided within 30 days. If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be filed within 180 days of your receipt of the decision regarding the first appeal. All decisions will be in writing. If you are enrolled in the Triple S PPO (or equivalent plan) in Puerto Rico, contact your provider directly for information about claims and appeals procedures. You must exhaust both levels of review in order to be eligible for External Review. See the External Review section on page 130 for more information.

Dental Claims

If you or your attending dentist wants the denial of benefits reviewed, you or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In any request for review, you or your attending dentist should state why the claim should not have been denied and include any other documents, data, information or comments which are thought to have bearing on the claim, including the denial notice.

If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received.

If you or your attending dentist believe the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the Enrollee or the

attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Life Insurance Claims

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will reevaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

Eligibility, Medical Reimbursement, Physical Exam or Hearing Aid Benefits, and Retiree Health Benefit Claims

Eligibility, medical reimbursement, physical exam or hearing aid benefits, and Retiree Health Plan claims and appeals are directed to the Board of Trustees of the Fund, which will provide one level of appeal. Ordinarily, decisions on appeals involving eligibility claims, medical reimbursement, physical exam or hearing aid benefits, or Retiree Health Plan benefits will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will 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;
- information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- the specific reason(s) for the determination, and, upon request, the denial code, if applicable
- a description of the Plan's standard, if any, that was used in denying the claim (in the case of a notice of final internal adverse benefit determination, this description will include a discussion of the decision)
- reference(s) to the specific Plan provision(s) on which the determination is based
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

External Review

If the outcome of the mandatory two levels of internal appeal is adverse to you, you will be eligible for an independent External Review pursuant to federal law if you meet all the following requirements:

- you were covered by the Fund at the time the health care item or service was requested or, for a retrospective review, were covered by the Fund at the time the item or service was provided
- the denial of the claim involved medical judgment or relates to a rescission of coverage
- you have exhausted the Fund's internal appeal process, or are not required to exhaust (for example you are appealing an urgent care claim), and
- you have timely provided all of the information and forms required to process an External Review.

The following types of claims are not eligible for external review:

- Life insurance claims
- Eligibility claims and any other denial based on a determination that you or your dependents are not eligible under the Plan.

When to Request External Review

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan or the applicable health organization has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation. Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

You must submit your request for External Review within four months of the notice that your claim was denied after the final (second) level of review. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the health organization's decision, can be sent between the health organization and you by telephone, facsimile or other similar method.

How to Request External Review

A request for External Review must be made in writing to the applicable health organization who heard the internal appeal unless the applicable health organization determines that it is not reasonable to require a written statement. Requests for external appeals for Triple-S benefits should be made to Empire Blue Cross Blue Shield. You do not have to re-send the information that you submitted for the review of your claim denial. However, you are encouraged to submit any additional information that you think is important for review.

How to Request an Expedited External Review

To proceed with an Expedited External Review, you or your authorized representative must contact the health organization that denied your claim on review and provide at least the following information:

- the identity of the claimant
- the date(s) of the medical service
- the specific medical condition or symptom
- the provider's name
- the service or supply for which approval of benefits was sought
- any reasons why the appeal should be processed on a more expedited basis.

If you qualify for an Expedited External Review, you do not need to first request an internal review from the entity that denied the claim.

There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through ERISA. For more information, please contact the entity that provided the service.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension 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. No lawsuit may be started more than three years after the end of the year in which medical or dental services were provided or the Fund rendered its final decision on eligibility.





Subrogation And Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses sustained by you or your eligible dependents, and you or your eligible dependents have a right to a recovery or have received a recovery from any source. A recovery includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you or your eligible dependents receive as a recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on behalf of you or your eligible dependents from any party responsible for compensating you or your eligible dependents for illnesses or injuries. The following provisions apply:

- The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you or your eligible dependents are fully compensated, and regardless of whether the payments you or your eligible dependents receive make you or your eligible dependents whole for your losses, illnesses and/or injuries.
- You or your eligible dependents and any legal representative of you or your eligible dependents must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your eligible dependents or legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you or your eligible dependents, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your or your eligible dependents' claim, attorney fees, other expenses or costs. The Plan does not recognize the "Make Whole" Doctrine.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you or your eligible dependents incur without the Plan's prior written consent. The Plan expressly rejects the "Common Fund" Doctrine. Accordingly, the "Common Fund" doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you or your eligible dependents obtain a recovery and the Plan has not been repaid for the benefits the Plan paid on behalf of you or your eligible dependents, the Plan shall have a right to be repaid from the recovery in the amount of the benefits paid on behalf of you or your eligible dependents, and the following provisions will apply:

- You or your eligible dependents must reimburse the Plan from any recovery to the extent of benefits the Plan paid on behalf of you or your eligible dependents regardless of whether the payments you receive make you whole for your or your eligible dependents' losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your or your eligible dependents' recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You or your eligible dependents and any legal representative of you or your eligible dependents must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon receipt of the recovery. You or your eligible dependents must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "Common Fund" Doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you or your eligible dependents fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your or your eligible dependents' recovery, whichever is less, from any future benefit under the Plan if:
 - the amount the Plan paid on your or your eligible dependents' behalf is not repaid or otherwise recovered by the Plan, or
 - you or your eligible dependents fail to cooperate.
- In the event that you or your eligible dependents fail to disclose to the Plan the amount of any settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your or your eligible dependents' recovery, whichever is less, directly from the providers to whom the Plan has made payments on your or your eligible dependents' behalf. In such a circumstance, it may then be your obligation to pay the provider the full-billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.
- The Plan does not recognize the "Make Whole" Doctrine and, therefore, is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or your eligible dependents or make you or your eligible dependents whole.



Your Duties

- You or your eligible dependents must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you or your eligible dependents occurred and all information regarding the parties involved.
- You or your eligible dependents must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your eligible dependents or any legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You or your eligible dependents must not do anything to prejudice the Plan's rights.
- You or your eligible dependents must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you or your eligible dependents.
- You or your eligible dependents must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on behalf of you or your eligible dependents.

The Board of Trustees has sole discretion to interpret the terms of the subrogation and reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent or other representative shall be subject to this provision. Likewise, if the covered person's relatives, heirs and/or assignees make any recovery because of injuries sustained by the covered person, that recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.



The Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the IATSE National Health & Welfare Fund, that provide health benefits, protect the privacy of your personal health information. (These rules do not apply to the life insurance provided under our Plan.) A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is distributed to new Plan enrollees and is available from the Fund Office. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Your "protected health information" is information about you, including demographic information, that:

- is created or received by the Plan, your health care provider or a health care clearinghouse (and is not related to your non-health benefits under the Fund, e.g., disability)
- relates to your past, present or future physical or mental condition
- relates to the provision of health care to you
- relates to the past, present or future payment for the provision of health care to you
- identifies you in some manner.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan (except for any information that is received in connection with the life insurance benefit) is referred to below as "protected health information," or "PHI."

Generally the Plan will require that you sign a valid authorization form (available from the Fund Office or the applicable Claims Administrator) 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. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

The Board of Trustees agrees to the following rules in connection with your PHI:

- The Board of Trustees understands that the Plan will only disclose health information to the Board of Trustees for the Trustees' use in Plan administration functions.
- Unless it has your written permission, the Board of Trustees will only use or disclose PHI for Plan administration, or as otherwise permitted by this Summary Plan Description, or as required by law. 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 (sometimes referred to as TPO). 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.
- The Board of Trustees will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.
- The Board of Trustees will not use or disclose your PHI for any employment-related actions or decisions, or with respect to any other pension or other benefit plan sponsored by the Board of Trustees without your specific written permission.
- The Board of Trustees will report to the Plan's Privacy Officer if the Trustees become aware of any use or disclosure of PHI that is inconsistent with the provisions set forth in this Summary Plan Description.
- The Board of Trustees will allow you, through the Plan, to inspect and photocopy your PHI, to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will make available PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA.
- The Board of Trustees will keep a written record of certain types of disclosures it may make of PHI, so that it may make available the information required for the Plan to provide an accounting of certain types of disclosures of PHI.
- If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.
- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:
 - Executive Director
 - all department directors
 - Health & Welfare Fund staff
 - other staff as needed for their jobs.
- These employees will be permitted to have access to and use the PHI only to perform the Plan administration functions that the Board of Trustees provides for the Plan.
- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the participants whose privacy has been violated.

- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.
- The Board of Trustees will return to the Plan or destroy all your PHI received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

There are also some special rules under HIPAA related to “electronic health information.” Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

The Board of Trustees has taken additional steps with respect to the implementation of security measures for electronic protected health information, as follows:

- The Board of Trustees has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health Plan.
- The Board of Trustees has ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures.
- The Board of Trustees has ensured 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.
- The Board of Trustees will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The Board of Trustees will comply with any other requirements that the Secretary to the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or guidance pursuant to HIPAA.





Genetic Information Non-Discrimination Act (GINA)

Effective for plan years beginning on or after May 21, 2009, GINA prohibits discrimination by group health plans such as the Plan 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 Plan is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Plan.



Your Rights Under The Employee Retirement Income Security Act Of 1974 (ERISA)

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.



Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

Assistance with Your Questions

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

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210.

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



Other Information You Should Know

Board of Trustees

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

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this SPD, the Trust Agreement or other Plan documents
- process and approve or deny benefit claims
- determine the standard of proof required in any case.

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

The Board of Trustees also reserves the right in its sole and absolute discretion to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan's termination (which might occur if the Union and the employers negotiate the discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to



continue), the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Fund assets have been disbursed. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and IATSE representatives.

Collective Bargaining Agreement and Contributing Employers

The Fund is established and maintained in accordance with one or more collective bargaining agreements. A copy of any such agreement(s) may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

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

Recovery of Overpayments

If for any reason benefit payments are made to any person from the Fund in excess of the amount which is due and payable for any reason (including, without limitation, mistake of fact or law, reliance on any false or fraudulent statements, information or proof submitted by a participant, or a participant's failure to timely inform the Fund of relevant information, such as a divorce), the Trustees (or the Plan Administrator or any other designee duly authorized by the Trustees) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest and costs). That authority shall include, but not be limited to:

- the right to reduce benefits payable in the future to the person who received the overpayment
- the right to reduce benefits payable to a surviving spouse or other beneficiary who is, or may become, entitled to receive payments under the Plan following the death of that person, and/or
- the right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and costs) against the person who received the overpayment, or such person's estate.

Assignment of Plan Benefits

Except as otherwise specifically set forth elsewhere in this Plan, authorized by the Plan in writing or required by law, any attempt to assign benefits or rights (including, without limitation, rights to sue) under this Plan are prohibited, whether or not the Plan has made any benefits payments to any third parties.



Plan Information

Official Plan Name	IATSE National Health & Welfare Fund
Employer Identification Number (EIN)	23-7333434
Plan Number	501
Plan Year	January 1–December 31
Type of Plan	An employee welfare benefit plan that provides medical, prescription drug, vision, dental and life insurance benefits
Effective Date	This Summary contains the rules in effect as of June 1, 2020.
Funding of Benefits	<p>The benefits described in this SPD are provided through employer contributions and, in some cases, employee contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of contribution. The Fund Office will provide to participants and beneficiaries, upon written request and as required by law, information as to whether a particular employer is contributing to the Fund on behalf of employees. The amount of any employee contributions made is determined as the difference between the cost of the applicable coverage and the amount of any employer contributions received on the employee's behalf.</p> <p>Currently, medical benefits, hospitalization, prescription drug, dental, physical exam, hearing aid and medical reimbursement benefits are self-funded, which means they are paid directly out of Fund assets, rather than through an insurance policy. In most cases, the Fund has contracted with outside providers to administer these benefits. Life insurance benefits are insured through the Metropolitan Life Insurance Company ("MetLife") and in Puerto Rico through MetLife.</p> <p>Vision benefits are insured through Davis Vision.</p>
Trust Fund	All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses. The Fund's assets are invested in various investment options and are deposited or invested with banks according to guidelines and objectives adopted by the Board of Trustees.

Plan Sponsor & Administrator	<p>The IATSE National Health & Welfare Fund is sponsored and administered by a joint Board of Trustees composed of Union trustees and employer trustees. Employer trustees are selected by the employer associations. Union trustees are designated by the Union. The names and addresses of the Trustees appear in this SPD. They may be contacted at:</p> <p>IATSE National Health & Welfare Fund 417 Fifth Avenue 3rd Floor New York, NY 10016-2204 (212) 580-9092 (800) 456-FUND (3863)</p>
Participating Employers	<p>The IATSE National Health & Welfare Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Plan on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and union locals sponsoring the Plan may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.</p>
Agent for Service of Legal Process	<p>In the event of a legal dispute involving the Plan, legal documents may be served on:</p> <p>Anne J. Zeisler, Executive Director IATSE National Health & Welfare Fund 417 Fifth Avenue 3rd Floor New York, NY 10016-2204</p> <p>Legal process may also be served on any individual Trustee at the Fund Office address. For disputes arising under those portions of the Plan insured by MetLife or Davis Vision, service of legal processes may be made upon the applicable insurer at one of their local offices or upon the official of the Insurance Department in the state in which you reside.</p>



Administration And Contact Information

BENEFIT	ADMINISTRATOR/INSURER	TYPE OF FUNDING
<p>HOSPITAL AND HEALTH</p>	<p>Empire BlueCross BlueShield PPO Member Services P.O. Box 1407 Church Street Station New York, NY 10008-1407 (800) 553-9603 (800) 241-6894 (TDD for hearing impaired) 8:30 am to 5 pm weekdays www.empireblue.com</p> <p>BlueCard® PPO Program (800) 810-BLUE (2583) 24/7 www.bcbs.com</p> <p>Medical Management Program (800) 982-8089 8:30 am to 5 pm weekdays</p> <p>24/7 NurseLine and AudioHealth Library (877) TALK-2RN (825-5276) 24/7</p> <p>Fraud Hotline (800) I-C FRAUD (423-7283) 9 am to 5 pm weekdays</p> <p>Triple-S, Inc. Box 363628 San Juan, PR 00936-3628</p>	<p>Self-funded. The Fund pays the cost of benefits, which are administered by Empire BlueCross BlueShield.</p>
<p>PLAN C-MRP (MEDICAL REIMBURSEMENT PROGRAM)</p>	<p>National Health & Welfare Fund 417 Fifth Avenue 3rd Floor New York, NY 10016-2204 (212) 580-9092 (800) 456-FUND (3863)</p>	<p>Self-funded. Fund pays the cost of, and administers, the benefits.</p>

BENEFIT	ADMINISTRATOR/INSURER	TYPE OF FUNDING
PRESCRIPTION DRUG	CVS Health Health Claims Department See claim form for address (800) 929-2524 CVS Health Mail Service Pharmacy P.O. Box 2110 Pittsburgh, PA 15230-2110 www.caremark.com	Self-funded. Fund pays cost of benefits, which are administered by Health.
VISION CARE	Davis Vision Capital Region Health Park Suite 301 711 Troy-Schenectady Road Latham, NY 12110 (800) 999-5431 www.davisvision.com Lens 1-2-3® (800) LENS-123 (536-7123) www.Lens123.com	The Fund pays premiums to Davis Vision, and Davis Vision provides coverage.
DENTAL	Delta Dental One Delta Drive Mechanicsburg, PA 17055-6999 (800) 932-0783 www.deltadentalins.com/iatse ASO/SIDS P.O. Box 9005 Dept. 7 Lynbrook, NY 11563-9005 (800) 537-1238 www.asonet.com	Self-funded. Fund pays cost of benefits, which are administered by Delta Dental and ASO/SIDS.
PHYSICAL EXAMS AND HEARING AIDS	ASO/SIDS P.O. Box 9005 Dept. 7 Lynbrook, NY 11563-9005 (516) 396-5525 (NY) (877) 390-5845 (outside NY)	Self-funded. Fund pays cost of benefits, which are administered under a contract with ASO/SIDS.
LIFE INSURANCE	Metropolitan Life Insurance Company (MetLife) Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Phone: 1-800-638-6420, then press 2 Fax: 570-558-8645	Insured. Fund pays premiums to MetLife to provide coverage.
RETIREE HEALTH BENEFIT PLAN	National Health & Welfare Fund 417 Fifth Avenue 3 rd Floor New York, NY 10016-2204 (212) 580-9092 (800) 456-FUND (3863)	Self-funded. Fund pays cost of benefits.



Glossary

360° Health A program that provides you with personalized support through online health and wellness resources, discounts on health-related products and services and alternative therapies.

Adverse Determination (i) a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; (ii) 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 (iii) a rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Affiliated Local A local union chartered by or affiliated with the Union.

Annual In-Network Out-of-Pocket Maximum The most you will have to pay in in-network out-of-pocket costs (including deductibles, copays and coinsurance) on covered services received during the year. When you meet the out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of that calendar year. There are different limits for in-network and out-of-network benefits. Expenses used to meet the in-network maximum cannot be applied to the out-of-network maximum and vice-versa.

Annual Maximum The maximum amount the Plan will pay for covered expenses in one calendar year.

Annual Open Enrollment Runs from mid-November through December 15 each year. It is the time of year to evaluate all of the Plan's options and choose the right fit for you and your eligible dependents for the upcoming year. Changes during the year are permissible under certain circumstances described later on in this summary.

Annual Out-of-Network Out-of-Pocket Coinsurance Maximum The most you will have to pay in out-of-network out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the Plan pays 100% of the maximum allowed amount for covered expenses for the remainder of that calendar year. Deductibles, copays, and any amount above the out-of-network maximum allowed amount do not count toward the annual out-of-pocket coinsurance maximum.

Automatic Downgrade An automatic reduction in your coverage if the coverage you want requires a self-payment and you fail to make the payment (or it is received after the applicable deadline).

Automatic Enrollment Occurs if you do not enroll during optional enrollment and contributions to your account are sufficient to cover the \$150 administrative fee plus the current quarterly charge for Plan C-2 single coverage.

Beneficiary The person you name to receive any life insurance benefits provided by the Plan if you die.

Brand-Name Drug A prescription drug sold under the registered or trademarked name given to it by the drug manufacturer that holds the manufacturing and marketing rights to that drug.

CAPP (Contributions Available for Premium Payments) Account An account in your name that tracks the amount of employer contributions received on your behalf for coverage under Plan C.

Case Management Assistance and support available when you or a member of your family faces a chronic or catastrophic illness or injury.

Change in Family Status An event (such as marriage, divorce or the birth of a child) that allows you to change your enrollment election soon after the event occurs.

Coinsurance The percentage of a covered medical expense you pay.

Collective Bargaining Agreement A negotiated agreement between an employer and the Union or an Affiliated Local requiring contribution to the IATSE National Health & Welfare Fund. It determines the amount of contributions employers are required to make to the Fund for work in covered employment.

Combining CAPP Accounts A provision under Plan C that allows two Plan C participants who are married to direct employer contributions received on behalf of either of them to a single account.

Concurrent A claim or review during treatment.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) A law that requires that this Plan offer you and your eligible dependents the opportunity to extend health care coverage at group rates in certain instances (called qualifying events) when coverage under the Plan would otherwise end.

Contributing Employer An employer that has signed a collective bargaining agreement with the Union or an Affiliated Local. The Fund, the Union and Affiliated Locals may be contributing employers if they contribute to the IATSE National Health & Welfare Fund pursuant to a written agreement.

Copay The fee you pay for office visits and certain covered services when you use in-network providers.

Coverage Lapse A termination of all coverage under the Plan because your CAPP account balance is insufficient to cover the quarterly cost of the lowest-cost option and you fail to make a timely self-payment.

Coverage Quarter Three consecutive months of a calendar quarter (January-March, April-June, July-September, October-December) during which you are enrolled in Plan C.

Covered Employment Work covered by a collective bargaining agreement or another agreement that requires your employer to make contributions to the IATSE National Health & Welfare Fund on your behalf.

Covered Services Services for which the Plan pays benefits. Certain frequency or other limitations may apply.

CVS Health Mail Service Pharmacy The prescription drug mail service under the Plan through which you can fill your and your enrolled dependents' prescriptions for most maintenance and long-term drugs (those taken for more than 30 days).

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

Deductible The dollar amount you must pay each calendar year before the Plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, Plan C-1 and Plan C-2 will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. (Plans C-3 and C-4 do not cover out-of-network services.)

Dependent Children Natural children, stepchildren, children required to be recognized under a QMCSO and adopted children (including children to be adopted during a waiting period before finalization of the adoption).

Employee Someone working under a collective bargaining agreement with a contributing employer. Employee may include a full-time Fund employee, office and clerical employee and duly elected or appointed officer of the Union or an Affiliated Local if the respective Fund, Union or Affiliated Local is a contributing employer.

Employer Contribution Period The three consecutive months during which contributions received by the Fund Office on your behalf are applicable to a particular coverage quarter. For example, contributions received from August through October are applicable to the coverage quarter from January through March.

Employer Contributions Amounts that employers contribute to the Health & Welfare Fund on behalf of employees who are covered by the IATSE National Health & Welfare Plan C.

Family and Medical Leave Act (FMLA) The law that allows you to take unpaid time off for your own or a family member's serious illness or to take care of a new baby.

Forfeiture If there is no activity in a CAPP account for two consecutive calendar years. The balance in the account is forfeited.

Formulary A list of drugs that are preferred to treat specific conditions because of the effectiveness of the drug and/or the cost of the therapy.

Generic Drug A lower-cost equivalent of a brand-name drug. It is approved by the U.S. Food and Drug Administration (FDA) and has the same active ingredients as its brand-name equivalent.

Health Care Professional For the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Hospital/Facility For purposes of certifying inpatient services under the Empire portion of the Plan, a hospital or facility that is a fully licensed acute-care general facility and meets certain requirements. See pages 58 and 59 for a complete description.

In-Network Benefits Benefits for covered services delivered by in-network providers, suppliers, hospitals and other health care facilities. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier/Hospital/Facility A doctor or other professional provider, durable medical equipment, home health care or home infusion supplier, hospital or other facility that:

- is in Empire's network
- is in the network of another BlueCross and/or BlueShield plan, or
- has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a network.

Mandatory Generic A plan design feature that treats multi-source drugs like generic drugs.

Maximum Allowed Amount The maximum amount the Plan reimburses for services and supplies. In-network providers have agreed to accept the maximum allowed amount as payment in full for services. Out-of-network providers may bill you for amounts above the maximum allowed amount and you will be responsible for paying any amount charged above the maximum allowed amount. For more detail on the maximum allowed amount see the section "How Much You Will Pay—Maximum Allowed Amount" on page 67.

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

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

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

Multi-Source Brand Name Drug A prescription drug that has a generic equivalent.

Optional Enrollment Your first opportunity to enroll in Plan C, which occurs when contributions to your account are sufficient to cover the \$150 administrative fee plus the current monthly charge for Plan C-2 single coverage.

Out-of-Network Benefits Benefits for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance, which means higher out-of-pocket costs for participants.

Out-of-Network Provider/Supplier/Hospital/Facility A doctor or other professional provider, durable medical equipment, home health care or home infusion supplier, hospital or other facility that:

- is not in Empire's network
- is not in the network of another BlueCross and/or BlueShield plan, and
- does not have a negotiated rate with another BlueCross and/or BlueShield plan.

Participation Termination You lose your eligibility for participation in Plan C because your CAPP account balance for the next coverage quarter is zero and, over the preceding 24 months, contributions made by employers on your behalf have been less than the quarterly charge for Plan C-2 single coverage.

Plan Administrator/Sponsor The person who has certain authority concerning the Plan, such as Plan management, including deciding questions of eligibility for participation, and/or the administration of Plan assets. The Board of Trustees is the Plan Administrator/Sponsor.

Plan C-MRP (Medical Reimbursement Program) An option under Plan C that helps you pay for health care expenses in one of two ways. If you provide acceptable proof that you have other medical coverage that complies with the Affordable Care Act, you can enroll in Plan C-MRP as a standalone option and use your entire account balance for eligible medical expenses. If you enroll in Plan C-1, C-2, C-3, or C-4 and there is "excess" funding in your CAPP account, you can use Plan C-MRP as a supplemental option for eligible medical expenses. Excess funding refers to any amount in your account as of the end of the applicable employer contribution period that exceeds the cost of your coverage for the current and subsequent coverage quarter.

Precertified Services Services that **must** be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be covered by the Plan. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

Provider A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional health care practitioner under the Empire portion of the Plan. Empire will pay benefits only for covered services within the scope of the practitioner's license. For behavioral health care purposes, "provider" includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post licensure supervised experience in psychotherapy. For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Qualified Medical Child Support Order (QMCSO) A court order that requires an employee to provide medical coverage for his or her children in situations involving divorce, legal separation or a paternity dispute.

Quarterly CAPP Statement The report that is mailed to Plan C participants before the start of each coverage quarter for the purpose of electing coverage for that quarter.

Retrospective Review A review that is conducted after you receive medical services.

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

Self-Payments Quarterly payments you make toward the cost of your health care coverage if employer contributions to your CAPP account are insufficient for coverage or for the level of coverage you want.

Special Enrollment A Plan provision that allows you to enroll yourself or a dependent in Plan C or upgrade to Plan C-1 or C-2, because of a change in family status or losing coverage under another plan.

Spouse A partner to whom you are legally married under state and federal law.

TRICARE A health care program provided by the government for uniformed service members and their families.

Uncombining CAPP Accounts A provision under Plan C that allows two Plan C participants to separate a combined account into two individual accounts.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) Provides rights concerning health care coverage to employees who take a military leave.

Union The International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada.

Urgent Precertification Precertification that is associated with medical circumstances that require a quick decision.

Year of Service A calendar year in which you were covered under the Health & Welfare Fund as a participant for at least six consecutive months.

Health & Welfare Board of Trustees

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The Segal Company





