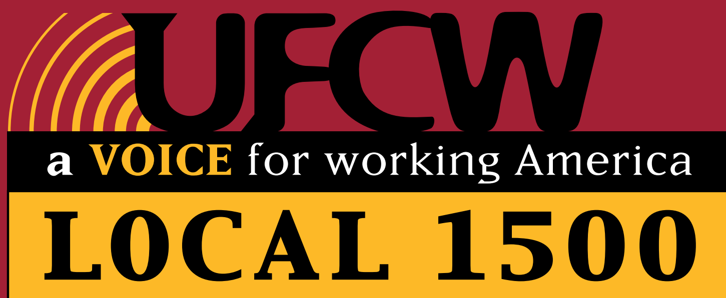

FULL TIME EMPLOYEES GROUP BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

U.F.C.W. Local 1500 Welfare Fund
Full Time Plan

Welfare Fund Office
425 Merrick Avenue
Westbury, NY 11590
(800) 522-0456
(516) 214-1300
Website: www.ufcw1500.org

Third Party Administrator
Associated Administrators, LLC
PO Box 1095
Sparks, MD 21152
(855) 266-1500
Hours: 8:30am to 4:30pm, Monday through Friday
Website: www.associated-admin.com

Online Member Service
MemberXG

Secure internet access to your information
Mobile-ready access – view your information 24/7
Review and print your EOBs
Health Claims – displays claims submitted
Demographics – view for member/dependent(s)
Eligibility – view past and present eligibility

How Does Member XG Work?

1. Log into www.associated-admin.com
2. Select “your benefits” and select “U.F.C.W. Local 1500 Welfare Fund”
3. At top of Local 1500’s home page select “Member XG”
4. Select “Create Account” (top right corner)
5. Create a username and password
6. View information

If English is not your primary language, you may be eligible for assistance in the non-English language in which you are knowledgeable. Please call Associated Administrators, LLC at (855) 266-1500 for more information.

NOTA: Si no saben leer y escribir en Inglés, usted puede ser elegible para recibir asistencia en el lenguaje no-Inglés en el que está alfabetizada. Por favor llame Associated Administrators, LLC en (855) 266-1500 para más información

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PLAN MANAGER'S MESSAGE

U. F. C. W. LOCAL 1500 WELFARE FUND
425 Merrick Ave
Westbury, NY 11590
516-214-1300 or 800-522-0456

December 1, 2018

Dear Participant,

In this booklet you will find information about your hospital and medical benefits utilizing the Anthem (Empire BlueCross/BlueShield) Network of providers. You will also find information about the Fund's Out-Of-Network Medical Benefits, Prescription Drug Benefits, Annual Medical Examination Benefit (provided by PEMG), Dental Benefits and Vision Care Benefits. The Prescription Drug Benefits are administered by Express Scripts, Inc.

Additionally, the Fund provides you with Group Term Life Insurance, Accidental Death and Dismemberment Insurance, as well as New York State Disability Benefits. Disability Benefits are for those Participants whose employer does not provide them through a policy issued to the employer. These three benefits are underwritten by Anthem Life & Disability Insurance Company and/or its subsidiary, Unicare (for the Disability Benefits). These benefits are also outlined in this book. These benefits are for you only. There is no coverage for dependents for these benefits.

In order for you and your eligible dependents to receive all of the benefits to which you are entitled and also know the claim procedures to be followed, we advise you and your eligible dependents to read this book carefully and keep it in a safe place for future reference.

It gives your Union and Welfare Fund Trustees great satisfaction to be able to make this benefit program available to you and your dependents, so that we may help you to maintain good health.

Fraternally yours,

Anthony G. Speelman
Plan Manager

Employer Trustees
Patrick J. Durning
Charles Farfaglia
Robert M. Jandovitz
Robert Spinella

Union Trustees
Anthony G. Speelman
Robert W. Newell, Jr.
Rhonda Nelson
Joseph Waddy

ADMINISTRATIVE INFORMATION

If you have any questions about this statement or about your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA), you should contact the nearest area office of the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

1. PLAN NAME: U.F.C.W. Local 1500 Welfare Fund, Group Benefit Plan for Full-Time Employees.
2. EDITION DATE: This Plan and the benefits herein is effective as of December 1, 2018.
3. PLAN SPONSOR: Board of Trustees of the U.F.C.W. Local 1500 Welfare Fund.
4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 23-7176373
5. PLAN NUMBER: 501 (assigned by federal government).
6. TYPE OF PLAN: Welfare Plan providing group term life insurance, group accidental death and dismemberment insurance, New York State statutory disability insurance (where applicable), hospital, medical, prescription drug, dental and vision benefits.
7. PLAN YEAR ENDS: December 31.
8. PLAN ADMINISTRATOR: Board of Trustees of the U.F.C.W. Local 1500 Welfare Fund, 425 Merrick Ave, Westbury, NY 11590, Telephone No. (516) 214-1300.
9. AGENT FOR THE SERVICE OF LEGAL PROCESS: Board of Trustees, U.F.C.W. Local 1500 Welfare Fund, 425 Merrick Ave, Westbury, NY 11590, Telephone No. (516) 214-1300.
10. TYPE OF PLAN ADMINISTRATION: Fund administered by the Board of Trustees.
11. TYPE OF FUNDING: Self-funded hospital, medical, prescription drug, vision care and dental care benefits. Insured by the Anthem Life & Disability Insurance Company for group term life insurance and group accidental death and dismemberment insurance. Anthem's subsidiary, Unicare, provides the New York State statutory disability insurance, where applicable.
12. SOURCE OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the U.F.C.W. Local 1500 Welfare Fund pursuant to Collective Bargaining Agreements between the Employers and the U.F.C.W. Local 1500 and/or written agreements by and between an Employer and the Trustees. Employees who elect to receive coverage for hospital, medical & prescription drug benefits are required to make a weekly contribution.

13. COLLECTIVE BARGAINING AGREEMENT: This Plan is maintained in accordance with collective bargaining agreements and/or written agreements by and between an Employer and the Trustees. A copy of the relevant agreement(s) may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Fund Office.

14. PARTICIPATING EMPLOYERS: You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the Plan. If so, you may also request the employer's address.

15. PLAN BENEFITS PROVIDED BY: U.F.C.W. Local 1500 Welfare Fund.

16. ELIGIBILITY REQUIREMENTS, BENEFITS, AND TERMINATION PROVISIONS OF THE PLAN: See applicable sections of this booklet.

17. NO INSURANCE UNDER THE PBGC: Since this Plan is not a defined-benefit pension plan, it is not covered by the Pension Benefit Guaranty Corporation.

18. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the U.F.C.W. Local 1500 Welfare Fund.

Mr. Patrick J. Durning
Wakefern Food Corp.
33 Northfield Avenue
P.O. Box 7812
Edison, NJ 08818-7812

Mr. Anthony G. Speelman
U.F.C.W. Local 1500
425 Merrick Ave
Westbury, NY 11590

Mr. Charles Farfaglia
Fairway Group Holdings Corp.
2284 12th Avenue
New York, NY 10027

Mr. Robert W. Newell, Jr.
U.F.C.W. Local 1500
425 Merrick Ave
Westbury, NY 11590

Mr. Robert M. Jandovitz
King Kullen Grocery Company, Inc.
185 Central Avenue
Bethpage, NY 11714

Ms. Rhonda Nelson
U.F.C.W. Local 1500
425 Merrick Ave
Westbury, NY 11590

Mr. Robert Spinella
Stop & Shop Supermarket Co.
287 Bowman Avenue
Purchase, NY 10577

Mr. Joseph Waddy
U.F.C.W. Local 1500
425 Merrick Ave
Westbury, NY 11590

GENERAL PLAN INFORMATION

FINANCING

Who pays for the Plan?

Employers contribute to the Plan pursuant to collective bargaining agreements with the U.F.C.W. Local 1500, or written participation agreements with the Fund's Board of Trustees. Additionally, for Participants who elect hospital, medical and prescription drug benefits, a weekly contribution is required for hospital, medical and prescription drug benefits.

How are the Plan monies managed?

All of the Plan assets are held in trust by the Board of Trustees of the Welfare Fund for the participants and beneficiaries of the Plan. The Board of Trustees is responsible for the management of Fund assets.

May I pledge the claim money owed me for the purpose of obtaining a loan?

No. No benefits of the Plan shall, in any manner or to any extent, be assignable or transferable by the participant, except that an assignment of benefits to a provider for a covered service is permitted.

If the Plan is discontinued, what will happen to the assets of the Fund?

The assets of the Fund must be used only for the benefit of the participants and beneficiaries. Under no circumstances may money, which has been properly contributed to the Fund ever, be returned to any Employer or to the Union. In addition, no participant can receive any of the contributions made to the Fund except in the form of benefits.

ELIGIBILITY

INITIAL COVERAGE

Who is eligible for coverage under the Welfare Plan?

All full-time employees covered under a collective bargaining agreement between an employer and U.F.C.W. Local 1500 or a written agreement between an employer and the Fund's Board of Trustees, which requires the employer to contribute to the Welfare Fund on behalf of such employee. Full-time employees may also be covered under other written agreements between a contributing employer and the Welfare Fund, which requires the employer to contribute to the Welfare Fund on behalf of such employees.

When will you become covered?

Eligible employees, along with their eligible dependents, will become covered for benefits on the first day of the month following the date the eligible employee completes sixty (60) days of continuous full-time employment with a contributing employer, in a position for which the employer is required to make contributions to the Fund pursuant to a collective bargaining or other written agreement.

A weekly employee contribution is required to receive hospital, medical and prescription drug benefits. If you choose not to enroll in the hospital, medical and prescription drug benefits, you and your eligible dependents will become covered for the dental and vision benefits after you satisfy the waiting period.

You will also become covered for Group Term Life Insurance and Group Accidental Death and Dismemberment Insurance on the date you become covered under the Plan. For Participants of certain contributing employers, the New York State Disability Insurance will become effective immediately upon your employment, if the Fund is obligated to cover you through a particular employer. Please be advised that only certain employers provide this benefit to their employees through the Fund. You are urged to contact your employer to ascertain if New York State Disability Insurance is provided through the Fund or by your employer. Please note, the Group Life, Accidental Death & Dismemberment and New York State Disability benefits are not available for eligible dependents. These are Participant only benefits.

If you are not working full-time on the day you would ordinarily become covered (for reasons other than health), the coverage for you and your eligible dependents will be delayed until you return to full-time work to the extent allowable by law.

Who are your eligible dependents?

Your eligible dependents are as follows:

(a) Your eligible spouse is the individual to whom you are lawfully married, unless legally separated. However, your lawful spouse will be eligible for hospital, medical and prescription drug coverage only if your spouse certifies that he or she does not have any other available health coverage, or if he or she has other available health coverage and he or she has taken/enrolled in such coverage. The cost of any other available coverage is not a determining factor to eligibility under the U.F.C.W. Local 1500 Welfare Fund.

Additionally, if your spouse accepts a payment for waiving health coverage under his or her employer's coverage or if your spouse refuses any coverage offered to him or her, he or she cannot be covered for hospital, medical and prescription drug benefits under the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan ("Plan").

Any dependent spouse not eligible for hospital, medical and prescription drug benefits under the Plan may be eligible for dental and optical benefits.

A spouse not enrolled in the Plan for hospital, medical and prescription coverage will be eligible to enroll in the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan upon losing coverage under his/her employer's plan or other group health plan. Coverage for such spouse will begin on the first day of the month following such termination of coverage, provided that the U.F.C.W. Local 1500 Welfare Fund is notified within 30 days of such termination and evidence of such termination is supplied to this Fund with the request to enroll the spouse in this Plan.

(b) Your children from birth until the end of the month in which the child reaches age 26*.

*A child who is physically or mentally incapable of self-support upon reaching age 26 (and is covered under the Plan on that date) may be continued under the Plan while remaining physically or mentally incapable of self-support and unmarried, subject to your own coverage continuing in force. Proof of such incapacity must be received by the Fund Office within 30 days after coverage would otherwise terminate. Final approval of such coverage will rest with the Board of Trustees. Additional proof of continuing incapacity may be required from time to time.

(i) The definition of "Children" includes natural children, stepchildren and adopted children (including a "proposed adopted child" during any waiting period prior to the finalization of the child's adoption) and foster children, as well as your own children, provided they meet requirements in (b) above. Evidence of this relationship/responsibility is required.

(ii) Newborn Child or Newborn Adopted Child: A newborn child will be covered from date of birth. A newborn adopted child will be covered from the date of birth provided: (i) you take custody of the child upon the child's release from the hospital and (ii) you file a petition to adopt within 30 days after

the child's birth. However, no benefits will be provided from birth if (1) the natural parent has coverage available for the child's care or (2) a notice revoking the adoption has been filed; or (3) one of the child's parent's revokes consent to adoption.

(iii) Furthermore, federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are state court orders or administrative orders requiring a parent to provide medical support to a child. A QMCSO may require the Plan to make coverage available to your child even though, for income tax purposes or purposes of the Plan, the child is not your legal dependent. In order to qualify as a QMCSO, the Medical Child Support Order must be issued by a court or administrative agency, clearly specify the alternate recipient, reasonably describe the benefits to be provided to such alternate recipient, and clearly state the period to which the order applies. Upon Plan approval of a QMSCO, a Plan is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order. You and the affected child will be notified if an order is received and you may receive a copy of the Plan's procedures for determining the status of a Qualified Medical Child Support Order, if you so request. A child covered under the Plan pursuant to a QMCSO will be treated as an eligible dependent under the Plan.

If you have a newly acquired dependent child as a result of a birth or the adoption of a newborn child, a birth certificate or adoption documentation, along with the child's Social Security number, must be presented within 30 days of the birth. Coverage for a dependent child, as a result of a birth or such adoption, will be retroactive to the birth date, after receipt of the birth certificate or adoption papers. If the birth certificate or adoption papers of the newborn child are not received within 30 days, benefits for the child will be suspended until receipt of the required documents. For any such child whose benefits are suspended, coverage will be reinstated retroactively to the date the benefits were suspended if the birth certificate or adoption papers are received within 6 months of the birth or adoption. In all other cases, coverage will be reinstated on the first of the month following receipt of the documents.

For newly acquired dependents as a result of a marriage, adoption, or placement for adoption, other than a newborn child, you may enroll your newly acquired dependent in the Plan, provided that you request enrollment within 30 days after the marriage, adoption or placement for adoption. No new dependent will be eligible for coverage under the Plan until he or she has been reported to the Fund Office by the Participant. Appropriate documentation of eligibility as a covered dependent (i.e., birth certificate, marriage certificate, etc.) must be sent to the Fund Office along with the notification. Coverage for a newly acquired dependent will begin on the first day of the month following proper notification, unless otherwise noted. Newly reported spouses and children are subject to all Plan rules and guidelines. A new dependent is defined as an individual who becomes a dependent of a Participant after the Participant is eligible to receive benefits.

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

An eligible dependent child will only be considered an eligible dependent of one (1) Participant. If two (2) Participants have a mutual child, they must elect, in writing, which parent will cover such child. Such election must be notarized and signed by both Participants. Such election will continue, unless revoked in writing. Any such revocation of election must be notarized and signed by both Participants and will become effective on the first day of the following month.

If you are hired on or after January 1, 2015 and you are declining enrollment for you and/or your eligible dependents because of other health coverage, you may, in the future, be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after the other coverage terminates. If you are hired on or after January 1, 2015 and you are declining enrollment for other reasons, you may be able to enroll provided such election is permissible under your employer's eligibility guidelines. If permissible, coverage will begin on the first day of the month following proper notification to the employer and the receipt and processing of the election form by the U.F.C.W. Local 1500 Welfare Fund Office.

No one will be eligible to be covered as a dependent while covered as an employee. Additionally, the Plan will not cover a Participant while on active duty in any service of the Armed Forces, except as provided for in item 5 below.

TERMINATION OF COVERAGE

When will coverage terminate?

The coverage for you and your eligible dependents will terminate as follows:

1) If you cease to be employed by a contributing employer, your eligibility continues to the end of the month in which your employment ceases.

2) If your employer ceases to be a contributing employer (or fails to make necessary contributions on a contractual due date), your eligibility continues to the end of the month in which your employer's contribution ceases.

3) If the Plan is discontinued or a specific benefit is terminated, coverage terminates on that day. You will receive advanced notice of any termination of specific benefits.

4) A dependent's coverage will terminate on the last day of the month when he/she is no longer an eligible dependent, as defined above.

5) If you take a leave from employment for service in a designated branch of the United States Armed Forces, you can continue coverage under the Plan in accordance with the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) for up to 24 months of military service. You must elect to keep your coverage under the Plan and pay the full cost of coverage, which will be the COBRA premium. A Participant who elects to continue coverage under the Plan pursuant to USERRA may not then elect to receive COBRA coverage when the extended coverage pursuant to USERRA ends. Likewise, if you elect COBRA continuation coverage during this period, you may not then elect to continue coverage under the Plan pursuant to USERRA when your COBRA ends.

   If the period of military service is less than 31 days, there will not be a charge for this coverage. Upon re-employment after such leave, you are entitled to have coverage under the Plan reinstated on the date you return to work, without a waiting period (except in the case of certain service-related medical conditions). Should you be activated for military service, contact the Fund Office.

6) If you take a leave of absence pursuant to the Family and Medical Leave Act of 1993 (FMLA), and you work for an employer who has 50 or more employees on each working day of 20 or more weeks in the current or preceding year and you meet the criteria of an "Eligible Employee" established in the law, your employer must maintain your health benefits up to a maximum of twelve (12) weeks in a twelve (12) month period, as if you had continued employment during your leave.

If you cease work for any reason, immediately contact the Welfare Fund Office to ascertain what coverage, if any, can be continued in force.

What happens if I cannot work because of illness or injury due to accident?

If you become disabled (as defined on page 17) after becoming covered under the Plan, and are unable to work due to illness or an injury due to an accident, your coverage will be extended for both you and your eligible dependents for a period of up to six (6) months from the last day of the month worked or until you are able to return to work, whichever occurs first. The six (6) month period begins on the first day of the month following the onset of your disability.

If your disability is the result of an accident or sickness covered under Workers' Compensation Law, coverage under the Welfare Fund for both you and your eligible dependents will be extended for up to an additional six (6) months, for a maximum total of twelve (12) months or until you return to work, whichever occurs sooner.

Should you take a leave from your employment due to disability or Workers' Compensation, you are urged to contact the Fund Office as soon as you take your leave.

What happens if I die?

If you die while covered under the Plan, coverage for your eligible dependents enrolled in the Plan as of the date of your death will continue until the end of the sixth calendar month following the death. Thereafter, your eligible dependents may apply for COBRA continuation coverage. (See COBRA section page 114.)

How does the extension of benefits for my disability and death affect my COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) rights?

Any period of extended coverage, due to your death or your inability to work due to a disability and/or Workers' Compensation leave, will be deducted from the applicable COBRA coverage period (i.e., six months of extended coverage due to disability will reduce the 18 month maximum COBRA coverage to a maximum of twelve (12) months). However, you and your eligible dependents receiving COBRA coverage may be entitled to an 11 month extension of COBRA allowing for up to a maximum of 29 months of COBRA coverage, if the Social Security Administration determines you are totally disabled. (See COBRA section page 114.)

What happens when I retire?

Certain retirees receiving a pension under the U.F.C.W. Local 1500 Pension Fund are entitled to a self-funded death benefit and retiree medical benefits from the U.F.C.W. Local 1500 Welfare Fund. You must meet specific criteria regarding age and length of service to be eligible for these benefits. Please be advised that in order to receive retiree benefits, there can be **no break in coverage**. You must be enrolled in the Retiree Plan **immediately** following coverage in the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan. You are urged to contact the Fund Office **before** you retire to ascertain your eligibility for retiree benefits under the U.F.C.W. Local 1500 Welfare Fund.

DEFINITIONS

Board Certified Specialist – A licensed physician who is certified in a medical specialty. Board Certification indicates advanced education and expertise in a particular medical specialty. Medical Doctors (MD) receive their Board Certification through the American Board of Medical Specialists, and Osteopathic Doctors (DO) receive their Board Certification through American Osteopathic Association.

Covered Charges mean the usual and customary charges (see definition below) and the Anthem fee allowances for medically necessary services and treatment of covered medical conditions. Medical necessity is determined according to accepted standards of medical practice. The Board contracts with HealthLink Medical Management to make the determination of medical necessity for certain cases. Please see page 24.

Elective Surgical Procedure – A non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and performed while the patient is confined in a hospital as an inpatient or in an ambulatory surgical center.

Some examples of common elective surgical procedures are:

- Total knee or hip joint replacement
- Herniated lumbar intervertebral disc removal
- Tonsillectomy and adenoidectomy
- Varicose Vein Ligation
- Deviated Septum (Non-Cosmetic)
- Appendectomy (Non-Emergency)
- Cesarean Sections (Non-Emergency)
- Hysterectomy
- Prostatectomy
- Cataract removal
- Hemorrhoidectomy
- Tympanotomy
- Arthroplasty
- Coronary Artery Bypass (Non-Emergency)
- Pacemaker Insertion (Non-Emergency)
- Bunionectomy

PLEASE NOTE: Any procedure, even those listed above, will not be considered elective if the operation is of an emergency nature (that is, must be scheduled without delay), as determined by the patient's surgeon or treating physician.

Fund Office means the office maintained by the Trustees of the U.F.C.W. Local 1500 Welfare Fund. It is located at 425 Merrick Ave, Westbury, NY 11590. The phone number is (516) 214-1300, or the toll free number is 1-800-522-0456 for all areas.

Home Health Agency – Any of the following: (1) a non-profit or public home health service having an approval certificate issued under a state public health law; or (2) a hospital having an operating certificate issued by New York State, to provide home health services; or (3) a home health agency as defined in Medicare; or (4) an agency which is certified by the patient's physician, has a full-time administrator, keeps medical records, and employs at least one registered nurse (RN) or has the services of a registered nurse available.

Hospital/Facility - 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;
- A license pursuant to any State, or agency of the State, responsible for licensing hospitals;
- Accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals;
- Clinical records of all patients;
- An organized staff of licensed doctors.

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Anthem or another BlueCross and/or BlueShield plan.

For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Anthem or participating with Anthem or another BlueCross and/or BlueShield plan.

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 Anthem to provide mental and behavioral healthcare services.

For alcohol and/or substance abuse, 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 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 Anthem or another BlueCross and/or BlueShield plan. In other states, the facility must participate with another BlueCross and/or BlueShield plan and must have an operating certificate issued by the state where services are rendered.

Anthem and the Fund do 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.

Illness means a bodily sickness, disorder, disease or pregnancy, which is not otherwise excluded from coverage.

Injury means all damage to you which is caused by an accident and which is not otherwise excluded from coverage.

In-Network Benefits are benefits for covered services delivered by In-Network providers and suppliers.

In-Network Provider/Suppliers are doctors, suppliers of durable medical equipment, pharmacies, etc., that have written agreements with the respective network (i.e., Anthem, Express Scripts, Inc., etc.) contracting with the Fund to provider access to services for Participants and their eligible dependents.

Medically Necessary means generally recognized in the physician’s profession as effective and essential for treatment of the injury or illness for which the service, treatment, supply or confinement is ordered and rendered at the appropriate level of care in the most appropriate setting based on the diagnosis. To be considered “Medically Necessary”, the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient’s condition or the quality of medical care. Medically Necessary must be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease, and not primarily for

the convenience of the patient, physician or his or her family or caretaker, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Service, treatment, supply, or confinement shall not be considered "Medically Necessary" if it is experimental, or is investigational, or is primarily limited to research in its application to the present injury or illness (except certified clinical trials mandated under The Affordable Care Act), or is primarily for scholastic, educational, vocational or developmental training (except certified clinical trials mandated under The Affordable Care Act).

A drug, device, or medical treatment or procedure will be considered experimental or investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- A recognized national medical or dental society, or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes only (except certified clinical trials mandated under The Affordable Care Act); or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment states that is experimental, investigational, or for research purposes (except certified clinical trials mandated under The Affordable Care Act).
- The medication is being used and/or prescribed outside of the FDA's approval (e.g., if a medication is approved for one condition only and is being prescribed for a different condition [i.e., "off-label usage"]).

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. HealthLink 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. 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.

The Plan shall not consider for reimbursement any expense incurred or paid for service, treatment or supply, including any hospital confinement charge, or charge for confinement in any facility or institution, which is not deemed "Medically Necessary"; and such expense shall not be deemed a covered expense under the Plan (except certified clinical trials mandated under The Affordable Care Act).

The Trustees reserve the right to review medical care and to make the determination as to whether the service, treatment, supply or confinement is or is not medically necessary.

The Trustees may rely on an independent reviewer for determination. The fact the physician or any other health care provider may order or recommend service, treatment, supply or confinement does not, of itself, make it medically necessary unless pursuant to a determination by an Independent Review Organization as mandated by the Affordable Care Act.

Out-of-Network Provider/Suppliers are doctors, suppliers of durable medical equipment, pharmacies, etc., that do not have agreements with the respective networks (i.e., Anthem, Express Scripts, Inc., etc.) contracting with the Fund to provider access to services for Participants and their eligible dependents.

Participant means an active full-time employee of an employer whose employment terms and conditions are subject to a collective bargaining agreement by and between said employer and the U.F.C.W. Local 1500 or subject to another written agreement by and between the employer and the Fund's Trustees and which requires the employer to contribute to the Welfare Fund on behalf of such employee.

Physician means a duly licensed Doctor of Medicine (MD) authorized to perform a particular health related service, acting within the lawful scope of his/her practice, and shall also include any other licensed health care provider or allied practitioner, including but not limited to a CSW, DDS, DMD, DC, DO, DPT, MSW, OD, PA, PT, PsyD, RN, acting within the scope of his/her license.

Plan means the U.F.C.W. Local 1500 Welfare Fund Plan for Full-Time Participants.

Plan Administrator means the Board of Trustees.

Policy means one or more of the master group insurance policies issued to the Fund. The Trustees reserve the right to change policy providers at any time.

Second Surgical Opinion is an opinion of a board certified specialist, based on his/her examination of the patient, of the advisability of an elective surgical procedure after another physician, licensed to practice medicine and perform surgery, has proposed to perform surgery, where the opinion is given prior to the performance of the surgery.

Totally Disabled or Total Disability, when used in reference to the health coverage provided by the Plan, means with respect to you, that you, due solely to injury or illness, are prevented from engaging in any occupation or employment. With respect to a covered dependent, this means that they, due solely to injury or illness, are prevented from engaging in substantially all of the normal activities of a person of like age and gender who is in good health. All determinations as to a participant's or covered dependent's disabled status are made in the Plan Trustees' (or their designee[s]) sole and absolute discretion.

Union means U.F.C.W. Local 1500.

Usual and Customary Charges means the usual charge made by a health care provider based upon similar providers who practice in the same geographic location. It shall also mean the usual charge made based upon comparable illness, such as a condition similar in nature and severity. The term "geographic location" means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

PAYMENT SCHEDULE OF BENEFITS FOR YOU AND YOUR DEPENDENTS

HealthLink Medical Management and Case Management Programs 1-877-284-0102

The Fund has contracted with HealthLink Medical Management and Case Management Programs for Utilization Review to ensure that all inpatient admissions and certain other treatments and procedures are necessary and appropriate and to ensure that treatments are performed in an appropriate setting. HealthLink must preauthorize all inpatient stays in a hospital (including all non-emergency admissions and urgent or emergency admissions) and certain other treatments. You are required to contact HealthLink for all emergency admissions within 48 hours of admission or as soon as practicable. Failure to precertify required services may result in a reduction or denial of benefits.

For maternity admissions, either in a hospital and/or birthing center, you should precertify your stay as soon as reasonably possible. It is recommended that you call HealthLink within the first 3 months of pregnancy, if possible.

See pages 24-27 for complete details on these programs.

IN-NETWORK HOSPITAL AND MEDICAL BENEFITS

In-Network Deductible

Before the Fund pays any benefits, an annual deductible must be met. The annual deductible is the first $100 of eligible expenses incurred by the individual during the calendar year or $200 of eligible expenses incurred by the family. The family deductible is calculated for all eligible payments by all covered family members. Once the annual family deductible is met, all remaining covered family members are deemed to have met their deductible. Once the respective annual deductible is met, the Fund will begin paying benefits.

In-Network Coinsurance

The Fund's In-Network benefits contain a coinsurance provision. Coinsurance is the percentage of in-network payments shared between the Fund and you. After the annual deductible has been met, the Fund pays 80% of the Anthem fee schedule allowance and you pay 20% of the Anthem fee schedule allowance, until the Fund's in-network out-of-pocket maximum for hospital & medical benefits is reached. Once an individual or family (as appropriate) has reached the calendar year out-of-pocket maximum, the Fund's payments increase to 100% of the Anthem allowance for eligible services and supplies and your coinsurance and copayments stop for the remainder of that calendar year. Please see below for the Fund's out-of-pocket maximum.

In-Network Copayment

The Fund's In-Network benefit contains a copayment for certain services. A copayment is a fixed amount you pay to providers, who have contracted with Anthem, for noted services. The copayment differs depending on the classification of the provider.

In-Network Out-of-Pocket Maximum for Hospital & Medical Benefits

The out-of-pocket maximum is the most you pay for covered expenses during the calendar year before the Fund begins to pay 100% of the Anthem fee schedule allowance. The out-of-pocket maximum is $ 1,100 per individual, $ 2,200 per family. Once an individual in the family meets their out-of-pocket maximum, there are no further copayments or coinsurance to be met for that person. The family out-of-pocket maximum is aggregated (i.e., all expenses paid by covered family members for that calendar year are applied to meet the family out-of-pocket maximum). Once the out-of-pocket family maximum is met, all remaining covered family members are deemed to have reached the out-of-pocket maximum.

Anthem Hospitalization Benefits

After satisfaction of the deductible, the Fund pays 80% of the Anthem fee allowance for eligible hospital charges in semi-private accommodations for room and board and medically necessary ancillary services for an unlimited number of days, until the applicable out-of-pocket maximum is reached. Once the out-of-pocket maximum is met, the Fund pays 100% of the Anthem fee allowance.

There is a $100 copayment for Emergency Room facility charges. This copayment is waived if you are admitted.

An important aspect of the hospitalization is the mandatory preauthorization of non-emergency confinements prior to a scheduled admission. In the case of an emergency admission, HealthLink Medical Management must be notified within 48 hours or as soon as practicable after admission. Failure to preauthorize a required hospital confinement will result in a reduction or denial of benefits.

See pages 28-37 for complete details on your hospital benefits.

PLEASE NOTE: There are no Out-of-Network benefits for hospital services, unless in an emergency situation and for substance abuse treatment.

Anthem Medical Benefits

After satisfaction of the annual deductible, the Fund pays 80% of the Anthem fee allowance for eligible services of participating Anthem providers, other than outpatient physician office visits, for the treatment of a covered illness or injury, up to the applicable out-of-pocket maximum. Thereafter, the Fund pays 100% of the Anthem fee allowance.

For outpatient physician office visits for the treatment of a covered illness or injury, a $20 copayment is required for Primary Care Physician visits and a $40 copayment is required for a Specialist visit.

For preventive care services, no coinsurance or copayment applies if services are provided by doctor or other provider in your network. Preventive care services are updated by the Affordable Care Act from time to time.

See pages 38-44 for complete details on these benefits.

OUT-OF-NETWORK MEDICAL BENEFITS

Out-of-Network Deductible

Before the Fund pays any benefits, an annual deductible must be met. The annual deductible is the first $500 of eligible expenses incurred by the individual during the calendar year. The annual family deductible is $1,000 of eligible expenses incurred by the family. The family deductible is calculated for all eligible payments by all covered family members. Once the annual family deductible is met, all remaining covered family members are deemed to have met their deductibles. Once the respective annual deductible is met, the Fund will begin paying benefits.

Out-of-Network Coinsurance

The Fund's Out-of-Network benefits contain a coinsurance provision. Coinsurance is the percentage of payments shared between the Fund and you. After you have met the annual deductible, for most services the Fund pays 70% of the usual & customary charges and you pay 30% of the usual & customary charges, for the treatment of a covered illness or injury, until the out-of-pocket maximum is met. For chiropractic services, the Fund's coinsurance is 50% of the usual & customary charges, which means the Fund pays 50% and you pay 50% of the usual & customary charges, until the out-of-pocket maximum is met. Once you have reached the Fund's out-of-pocket maximum, the Fund pays 100% of the usual & customary charges. Additionally, you are responsible for the difference between the Fund's payment and the billed charges.

Out-of-Network Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay for expenses during the calendar year before the Fund begins to pay 100% of the usual & customary charges. This amount never includes any "balance due" charges after the Fund's payment. The out-of-pocket maximum is $2,900 per individual, $5,900 per family. Once an individual in the family meets his/her out-of-pocket maximum, there are no further copayments or coinsurance to be met for that person. The family out-of-pocket maximum is aggregated (i.e., all covered expenses paid by covered family members for that calendar year are applied to the family out-of-pocket maximum). Once the out-of-pocket family maximum is met, all remaining covered family members are deemed to have reached the out-of-pocket maximum.

Out-of-Network Medical Benefits

The eligible Out-of-Network Medical benefits are described later in this booklet. These benefits include services (other than the Anthem expenses) for surgery, physicians' visits, laboratory tests, imaging (such as x-rays), rehabilitative therapies, habilitative therapies, durable medical supplies and many other items.

Inpatient hospital confinements are not covered under the Out-of-Network benefits, unless it is an emergency admission. For emergency hospital admissions and certain professional services noted later in the book, the Fund will pay benefits in accordance with the in-network benefit levels regarding coinsurance, copayments and out-of-pocket maximums.

PLEASE NOTE: Expenses eligible under Anthem In-Network benefits are excluded from coverage under the Out-of-Network Medical Benefit. Additionally, expenses eligible under the Anthem In-Network benefits cannot be used to satisfy the annual Out-of-Network deductible.

PRESCRIPTION DRUG BENEFIT

The U.F.C.W. Local 1500 Welfare Fund contracts with Express Scripts, Inc. (ESI) to administer the prescription drug benefit. The Fund's prescription drug benefit offers you coverage for your medications in two ways: one via a retail pharmacy and the other via a mail order service. The Plan allows for up to the greater of (1) a 34 day supply or (2) 100 units of medication to be filled at a retail pharmacy (provided these limits are within the drug quantity maintenance guidelines) and up to a 3 month supply of medication to be filled via the mail order service.

The Fund's Prescription Drug Benefit contains Utilization Management Programs ("UM"). Please see pages 55-57 for details on the UM programs.

The Prescription Drug Benefit is an incentive based formulary program. Under this program, medications are divided into three (3) categories: (1) generic drugs, (2) preferred brand name drugs and (3) non-preferred brand name drugs and specialty drugs. The classification of any drug is approved by the Trustees based upon the ESI's clinical determination of effectiveness.

Prescription Drug Benefit Copayment

The Prescription Drug Benefit has a three (3) tier copayment structure, which depends on the classification of the medication received and the manner in which the prescription is filled (i.e. retail pharmacy or mail order).

The copayment structure for medications received at a retail pharmacy is as follows: For generic medications, you pay 20% coinsurance, up to a maximum of $10 per prescription. For preferred brand name medications, you pay 20% coinsurance, up to a maximum of $25 per prescription. For non-preferred brand name medications and specialty medications, you pay 20% coinsurance up to a maximum of $50 per prescription.

The copayment structure for medications received via ESI mail order is as follows: For generic medications, you pay 20% coinsurance, up to a maximum of $20 per prescription. For preferred brand name medications, you pay 20% coinsurance, up to a maximum of $50 per prescription. For non-preferred brand name medications and specialty medications, you pay 20% coinsurance up to a maximum of $100 per prescription.

Out-of-Pocket Maximum for Prescription Drug Benefits

The out-of-pocket maximum is the most you pay for eligible expenses during the calendar year before the Fund begins to pay 100% of the ESI fee schedule allowance. The In-Network out-of-pocket maximum is $400 per individual, $800 per family. The Out-of-Network out-of-pocket maximum is $1,100 per individual, $2,100 per family. To calculate the out-of-pocket maximum, one individual must meet his/her out-of-pocket maximum. To calculate the family out-of-pocket maximum, all expenses incurred by the covered family members are accumulated. When the out-of-pocket maximum is reached, the Fund's payments increase to 100% of the Express Scripts allowance for eligible services and supplies, and your copayment stops for the remainder of that calendar year.

PLEASE NOTE: If you receive a brand name medication when there is a generic equivalent, you must pay the difference between the generic reimbursement level and the brand name reimbursement level, along with the required copayment.

Please see page 59 for information on excluded pharmacies. If a pharmacy is excluded from coverage, no payment will be made to that pharmacy.

DENTAL BENEFIT

The U.F.C.W. Local 1500 Welfare Fund pays a dentist's charge for a covered service, up to the amount listed for the particular service in the Schedule of Dental Procedures appearing in pages 64-67.

Annual Maximum Benefit Payable:

Participant $2,000

Spouse $1,500

Child Over Age 19 .... $1,250

Child Under Age 19.. No Annual Maximum

ORTHODONTIC BENEFIT

Maximum Lifetime Orthodontic Benefit is as follows:

For treatment by a dentist who is
A Board Certified Specialist* $1,822

For treatment by a dentist who is not
A Board Certified Specialist* .... $ 706

*A dentist who is certified to specialize in orthodontia by the American Board of Orthodontics will be deemed to be a Board Certified Specialist.

Please see page 68 for details on this benefit.

VISION CARE BENEFIT

The Plan pays charges for covered eye examinations and supplies; up to the amount listed in the Schedule of Vision Benefits appearing on page 70.

BENEFIT DESCRIPTIONS FOR YOU AND YOUR DEPENDENTS

HEALTHLINK MEDICAL MANAGEMENT PROGRAM

HealthLink's Medical Management Program is a service that reviews hospital admissions and certain treatments and procedures to ensure that you receive high quality care for the right length of time, in the right setting, with maximum allowable coverage. The Medical Management Program reviews claims before services are rendered and then precertifies the service or reviews services while they are ongoing (concurrent review services).

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

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

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

- Review planned and emergency hospital admissions, as well as rehabilitation facility admissions;
- Review ongoing hospitalization;
- Review inpatient and same-day surgery;
- Review high risk pregnancies;
- Review routine maternity admissions;
- Perform individual case management;
- Review care in a skilled nursing facility;
- Coordinate discharge planning.

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

REMEMBER: To receive the maximum allowable benefit, you must call HealthLink to precertify your services. Contact HealthLink's Medical Management Program at 1-877-284-0102.

Failure to Precertify

If you fail to precertify a required service, benefits may be reduced by 50%, up to $500 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 determined not to be medically necessary, no benefits will be paid.

Tips for Precertification

When you or your treating provider calls HealthLink Medical Management Program for pre-certification, be sure to have the following information about the patient ready:

- Name, birth date and gender of patient;
- Address and telephone number;
- Anthem I.D. card number;
- Name and address of the hospital/facility;
- Name and telephone number of the admitting doctor;
- Reason for admission and nature of the services to be performed.

Initial Decisions

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

1. *Precertification Requests.* Precertification means that you must contact HealthLink's Medical Management Program for approval before you receive certain health care services. HealthLink will review all requests for precertification within three (3) business days of receipt of the necessary information but not to exceed 15 calendar days from the receipt of the request. If HealthLink does not have enough information to make a decision within three (3) business days, it will notify you in writing of the additional information needed, and you and/or your provider will have 45 calendar days to respond. HealthLink will make a decision within three (3) business days of receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.

2. *Urgent Precertification Requests*. If the need for the service is urgent, HealthLink will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of receipt of the request. If the request is urgent and requires further information to make a decision, HealthLink will notify you within 24 hours of receipt of the request and you and/or your provider will have 48 hours to respond. HealthLink will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.

3. *Concurrent Requests*. Concurrent review means that HealthLink reviews your care during your treatment to be sure you get the right care in the right

setting and for the right length of time. HealthLink will complete all concurrent reviews of services within 24 hours of our receipt of the request.

4. *Retrospective Requests*. Retrospective review is conducted after you receive medical services. HealthLink will complete all retrospective reviews of services already provided within 30 calendar days of receipt of the claim. If HealthLink does not have enough information to make a decision within 30 calendar days, it will notify you in writing of the additional information needed, and you and/or your provider will have 45 calendar days to respond. HealthLink will make a decision within 15 calendar days of receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

If HealthLink'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 determined 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, HealthLink's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See the Fund's claim appeal procedures on pages 95 - 105.

If HealthLink'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 its decision. A response will be provided by telephone and in writing within one business day of making the decision.

NEW MEDICAL TECHNOLOGY

Requesting Coverage

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

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

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

Case Management

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

HealthLink's nurses can help you and your family:

- Find appropriate, cost-effective healthcare options;
- Reduce medical cost;
- Assure quality medical care.

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

- Cancer
- Stroke
- AIDS
- Chronic illness
- Hemophilia
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, HealthLink's Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact HealthLink's Medical Management Program at 1-877-284-0102.

Limitation as Independent Contractor

The relationship between the Fund, Anthem and participating hospitals, facilities or providers is that of independent contractors. Nothing herein shall be deemed to create between the Fund, Anthem and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. The Fund and Anthem are not 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.

In-Network Deductible

You must meet the annual deductible prior to any benefit being paid. The individual annual deductible is the first $ 100 of eligible expenses incurred during the calendar year. The annual family deductible is $ 200 of eligible expenses. An individual must satisfy the $100 deductible once each calendar year. However, the family deductible is calculated on an aggregated basis, which means all eligible charges incurred by covered family members are added together. Once the family deductible is met, all remaining family members will be deemed to have met their deductible from that date forward for the remainder of the calendar year without any additional deductibles being applied.

In-Network Coinsurance and Out-of-Pocket Maximum

Once the annual deductible is met, the Plan will pay 80% of the Anthem allowance for covered services. You must pay the other 20%, until you reach the Plan's out-of-pocket maximum. The in-network out-of-pocket maximum is $1,100 per individual; $2,200 per family. The family out-of-pocket maximum is aggregated among all covered family members. Once an individual meets his/her out-of-pocket maximum or the family meets the family out-of-pocket maximum, the Fund's payments increase to 100% of the Anthem allowance for eligible services and supplies and your 20% coinsurance stops for the remainder of that calendar year.

Hospital Benefits

The Plan covers medically necessary care when you stay at a network hospital for surgery or treatment of a covered illness or injury. No benefits are available when you use an out-of-network hospital, except in emergency situations and substance abuse.

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:

(a) Are performed in a same-day or hospital outpatient surgical facility;

(b) Require the use of both surgical operating and postoperative recovery rooms;

(c) May require either local or general anesthesia;

(d) Do not require inpatient hospital admission because it is not appropriate or medically necessary, and

(e) Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Remember to call HealthLink's Medical Management Program at 1-877-284-0102 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or emergency surgical procedure, call HealthLink within 48 hours or as soon as reasonably possible. Failure to precertify your hospital service may result in your benefits being reduced by 50%, up to $500 for each hospital admission or surgery. Benefit reductions will also apply to all care related to the admission, including physician services.

The medical necessity and length of any hospital stay are subject to HealthLink'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 HealthLink's Medical Management section for additional information.

When you use a network hospital, you will not need to file a claim, in most cases. The hospital will file the claim on your behalf.

Inpatient Hospital Care
Covered Services

Provided that the patient has followed the Fund's precertification requirements, the following are covered services for inpatient care:

- Semi-private room and board when:
  - A hospital stay is medically necessary; and
  - The patient is under the care of a physician

  Coverage is for unlimited days, subject to HealthLink's Medical Management Program review, unless otherwise specified;
- Operating and recovery rooms;
- Special diet and nutritional services while in the hospital;
- Cardiac care, intensive care units;
- General, special and critical nursing care;
- Services of a licensed physician or surgeon employed by the hospital;
- Care related to surgery;
- Breast cancer surgery (lumpectomy, mastectomy), including reconstruction following surgery, prostheses, surgery on the other breast to produce a symmetrical appearance and treatment of physical complications at any stage of a mastectomy, including lymphedemas, as required by the Women's Health and Cancer Rights Act of 1998. The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery. This coverage is subject to all coverage terms and limitations consistent with those established for other benefits under the Plan.

- Use of cardiographic equipment;
- Drugs, dressings, oxygen and other medically necessary supplies;
- 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, up to a maximum of 30 days of inpatient service per calendar year;
- Facilities, services, supplies and equipment related to medically necessary medical care.
- Inpatient Mental Health Care. Coverage is provided for inpatient treatment of mental and nervous disorders. Additional covered services and limitations for Inpatient Mental Health Care are:
  - Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Heathcare 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.
- Inpatient Alcohol or Substance Use Disorder Treatment. Coverage is provided for inpatient treatment of alcohol and substance use disorder treatment. All confinements must be precertified through HealthLink Medical Management. The Long Island Council on Alcoholism and Drug Dependence (LICADD) provides Substance Abuse services. Contact LICADD at 1-516-747-2606.

Non- Covered Inpatient Hospital Services

These inpatient services are **not** covered:

- Private duty nursing.
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's charge for a semiprivate room.
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life.
- Services performed in the following:
  - Nursing or convalescent homes
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except for physical therapy and treatment of alcohol and substance use disorders. See Inpatient Alcohol and Substance Abuse Treatment above)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps

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

Outpatient Hospital Care
Covered Services

The following are covered services for same-day care:

- Same-day and hospital outpatient surgical facilities.
- 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. Benefits are payable if (a) reservations for a hospital bed and for an operating room at that hospital have been made prior to the performance of the tests; (b) the covered person's doctor has ordered the tests; and (c) proper diagnosis and treatment require the tests. The scheduled surgery must take place within seven (7) days after these tests. If the surgery is canceled because of these pre-surgical test findings or as a result of a voluntary second opinion on surgery, the Fund will still cover the costs of these tests. The Fund will not cover these tests when the surgery is canceled for any other reason. You will be responsible for the charges.
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings, until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)
  - In a hospital-based or free-standing facility. See "Hospital/Facility" in the Definitions section.
- Rehabilitation Therapy. (Physical, Occupational, Speech and Orthoptic) There is a maximum of 30 visits per therapeutic service, combined in home, office or outpatient facility per calendar year for both in and out-of-network services combined.
- Habilitation Services/Therapies. There is a maximum of 30 visits combined in home, office or outpatient facility per calendar year for both in and out-of-network services combined.

Non-Covered Outpatient Hospital Care Services

These outpatient services are **not** covered:

- Same-day surgery deemed not medically necessary by HealthLink's Medical Management Program.
- Collection or storage of your own blood, blood products, semen or bone marrow.

EMERGENCY CARE BENEFIT

Emergency care is covered in the hospital emergency room. 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:

(a) 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;

(b) Serious impairment to such person's bodily functions;

(c) Serious dysfunction of any bodily organ or part of such person; or

(d) Serious disfigurement of such person.

There is a $100 copayment per visit to an emergency room. This copayment is waived if you are admitted to the hospital within 24 hours.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition.

Please note, if you are admitted to the hospital, you or someone on your behalf must call HealthLink's Medical Management Program before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from HealthLink within the required time, a penalty of 50%, up to a maximum of $500, of benefits will apply. Should a penalty be applied to your service, that amount is **not** included in the calculation of your annual out-of-pocket maximum.

Non-Covered Emergency Services

These emergency services are not covered:

(a) Use of the Emergency Room:

- To treat routine ailments;
- Because you have no regular physician or your primary care physician is unavailable;
- Because it is late at night or alternative care (such as stand-alone "Emergicare" or "Urgent Care" facility) is closed and the need for treatment is not sudden and serious.

(b) Ambulette.

Emergency Air Ambulance

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met: (1) Your medical condition requires immediate and rapid ambulance transportation; and (2) services cannot be provided by land ambulance due to great distances, and/or 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 HealthLink, and use of land ambulance would pose an immediate threat to your health.

If it is determined that the condition for coverage for air ambulance services have not been met but your condition did require transportation by land ambulance to the nearest acute care hospital, the Fund will only pay up to the maximum allowed amount that would be paid for land ambulance to that hospital.

Emergency Land Ambulance

The Fund 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:

(a) 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

(b) serious impairment to a person's bodily functions;

(c) serious dysfunction of any bodily organ or part of a person; or

(d) serious disfigurement to the member.

Benefits are not available for transfers between healthcare facilities, unless otherwise noted.

MATERNITY CARE

Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, the Fund cannot 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 Maternity Services

You are covered for prenatal and postnatal care, as well as lab tests, sonograms and other diagnostic procedures, routine newborn nursery care and obstetrical care. There are no out-of-network facility benefits, unless in an emergency situation.

Following are additional covered services and limitations:

(a) One home care visit if the mother leaves earlier than the 48-hours for vaginal birth or 96-hours for C-section. The mother must request the visit from the hospital or a home health care agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.

(b) 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.

(c) Parent education and assistance and training in breast or bottle-feeding, if available.

(d) Circumcision of newborn males.

(e) Special care for the baby if the baby stays in the hospital longer than the mother. Call HealthLink's Medical Management Program to precertify the hospital stay.

(f) Semi-private room.

Non-Covered Maternity Services

These maternity care services are not covered:

(a) Days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits).

(b) Services that are not medically necessary.

(c) Private room.

(d) Out-of-Network birthing center facilities.

(e) Private duty nursing.

SKILLED NURSING

Precertification is required. Please call HealthLink at 1-877-284-0102.

Covered Services

You are covered for inpatient care in a participating skilled nursing facility if you need medical care, nursing care or rehabilitation services, up to a maximum of 60 days per calendar year. Prior hospitalization is not required in order to be eligible for benefits. No benefits are available for out-of-network facilities and services.

Services are covered if:

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

Non-Covered Skilled Nursing Services

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
  - Gives assistance with activities of daily living (ADL)
  - Is for rest or for the aged
  - Treats drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

HOSPICE CARE

Precertification is required. Please call HealthLink at 1-877-284-0102.

Covered Services

You are covered for up to 210 days of hospice care once in a covered person's lifetime. Hospice provides 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 Hospital (in the hospice area of an in-network hospital or facility) or at home, as long as it is provided by an in-network hospice agency. No benefits are available for out-of-network facilities and/or services.

Following are additional covered services and limitations:

- 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, medications, and nutritional services 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, when required for control of symptoms;
- 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;

HOME HEALTH CARE

Precertification is required. Please call HealthLink at 1-877-284-0102.

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage for home health care and home infusion therapy when you use an in-network provider. Home infusion therapy, which is a service sometimes provided during home health care visits, is only available in-network.

Covered Home Health Care Services

The following are covered services and limitations:

(a) Up to 200 home health care visits per calendar year when rendered within seven days of discharge from hospital. 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 provide a written treatment plan.

(b) Home health care services include:

- Part-time services by a registered nurse (RN) or licensed practical nurse (LPN);
- Part-time home health aide services (skilled nursing care);
- Physical, speech or occupational therapy, if restorative;
- Medications, medical equipment and supplies prescribed by a doctor;
- Laboratory tests.

(c) Home Infusion Therapy

(d) When care is rendered without prior hospitalization, you must pay a $50 deductible. You will receive an allowance equal to 75% of the agency's reasonable charges, for up to a maximum of 40 home care visits per calendar year.

Non-Covered Home Health Care Services

The following home health care services are not covered:

(a) Custodial services, including bathing, feeding, changing or other services that do not require skilled care.

(b) Out-of-network home infusion therapy.

ANTHEM IN-NETWORK MEDICAL SERVICES

Physician Services for the Treatment of an Illness or Injury

The Fund will cover physician services for the treatment of a covered illness or injury. You pay only the applicable copayment ($ 20 copayment per visit for primary care and family practice physicians and $40 copayment per visit for specialist visits), until your out-of-pocket maximum has been met. Thereafter, no further copayments are required. If you receive additional services that are billed separately from the physician charge, those services are covered at 80% of the Anthem fee allowance until you meet your out-of-pocket maximum.

There are no claim forms for you to fill out. The In-Network provider will submit the claim on your behalf.

LiveHealth Online Physician Services

The Fund also offers Anthem's LiveHealth Online physician's visits for mild, common conditions. You may access live on-demand, face to face video doctor visits 24 hours a day, 7 days a week, 365 days per year. This benefit can be accessed via your smartphone, tablet or computer. You will need to download the LiveHealth Online App from the Apple App Store or Google Play for Android devices. The download is free and will not cost you anything. This application is secure and private offering HIPAA compliant video visits, with the ability to have certain prescriptions electronically transmitted to your participating pharmacy of choice, if determined to be medically necessary by the physician.

This benefit is considered a covered physician office visit, with no copayment and is available in all states. This benefit provides access to your choice of board certified, Anthem network doctors.

Examples of some of the commonly treated medical conditions through this service are:

Abrasions/Minor Wounds, Anxiety, Asthma, Allergies/Allergic Rhinitis, Back Pain, Cough/Cold, Depression, Diarrhea, Ear Pain, Fever, Headache/Migraine, Influenza/flu, Insomnia, Nausea/Vomiting, Pinkeye/Other Eye Infections, Rashes/Skin Disturbances, Sinus Infection, Sore Throat/Pharyngitis, Sprains and Strains, Urinary Tract Infection.

Additional Physician Services for the Treatment of an Illness or Injury

The following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury;
- Diabetes self-management education and diet information;

- 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 dental in nature;
- Medically necessary hearing examinations to determine hearing loss;
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician.

Non-Covered Physician's Services

The following medical services are not covered:

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

Preventive Care Services

This Fund provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act (ACA). Coverage is provided with no cost sharing on an in-network basis only. In-network preventive services that are identified by the Fund as part of the ACA guidelines will be covered with no cost sharing. This means that the service will be covered at 100% of the Fund's allowable charge, with no coinsurance, copayment, or deductible.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Fund will determine whether a particular benefit is covered under this preventive services benefit. Preventive benefits may be updated from time to time.

Office Visit Coverage Under the Preventive Care Benefit

Preventive Services are paid for based on the Fund's payment schedules for the individual services. There may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Out-of-network office visits are not covered under the in-network preventive services benefit under any condition.

- If a preventive item or service is billed separately from an office visit, then the Fund will impose cost-sharing with respect to the office visit;
- If the preventive item or service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of such preventive item or service, then the Fund will pay 100 percent for the office visit;
- If the preventive item or service is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Fund will impose cost-sharing with respect to the office visit.

For example, if a person has a cholesterol-screening test during an office visit and the doctor bills for the office visit and separately for the lab work associated with the cholesterol-screening test, the Fund will require a copayment for the office visit, but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Fund will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well Women's Care visits established by the ACA are also treated as preventive services and paid at 100% of the allowable amount. These exams may change from time to time.

Well Child Care annual physical exams established by the ACA are treated as preventive services and paid at 100%. These exams may change from time to time.

In-Network Preventive Services Coverage Limitations and Exclusions

- Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services;
- Services covered under the Preventive Services benefit are not also payable under other Fund benefits.
- The Fund will use reasonable medical management techniques to control costs of the Preventive Services benefit. Specifically, the Fund will only cover the most cost-effective test methodology for all preventive tests and services on this list.
- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications);
- Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered;

- Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, (except certified clinical trials mandated under The Affordable Care Act);
- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  - When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
  - When related to judicial or administrative proceedings;
  - When related to medical research or trials, except where required by Federal Law;
  - When required to maintain employment or a license of any kind.
- Services related to male reproductive capacity, such as vasectomies and condoms, are not covered.

OTHER COVERED IN-NETWORK MEDICAL SERVICES

Other covered medical services include:

- Surgery, performed on an inpatient or outpatient basis. Precertification required. Contact HealthLink at 1-877-284-0102.

  For a second procedure performed during an authorized surgery through the same incision, the payment made is the highest maximum allowed amount. For a second procedure done through a separate incision, the payment is the maximum allowed amount for the procedure with the highest amount and up to 50% of the maximum allowed amount for the other procedure.

  This benefit is inclusive of benefits under The Women's Health and Cancer Rights Act of 1998. In the case of a covered person who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the Fund will cover:

  - Reconstruction of the breast on which the mastectomy has been performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

  The coverage under the Women's Health and Cancer Rights Act of 1998 shall be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example, Deductibles and Coinsurance) consistent with those established for other benefits under the plan.

- Anesthesia, in connection with a covered service.
- Diagnostic Laboratory and Imaging services (X-rays and other imaging, Radium and Radionuclide Therapy, MRIs/MRAs, Nuclear Cardiology Services, PT/CAT Scans, Laboratory Tests) & Screening. Precertification Required for MRIs/MRAs, nuclear cardiology services and PT/CT scans. Precertification required. Contact HealthLink at 1-877-284-0102.
- Diabetes Education and Management. The applicable copayment per visit is required.
- Allergy Care including office visits, testing and treatment. The applicable copayment per visit is required.
- Genetic testing, as required by the ACA.
- Chemotherapy and Radiation Therapy.
- Kidney Dialysis, until the patient becomes eligible for dialysis under Medicare.
- Second or Third Opinion for Cancer Diagnosis. The applicable per visit copayment is applicable.
- Rehabilitative Therapy, (Physical, Occupational, Speech and Orthoptic Therapy). There is a maximum of 30 visits per calendar year for each therapeutic classification. The 30 visit maximum is combined in home, office or outpatient facility per calendar year for both in and out-of-network services combined. Precertification Required. Please contact HealthLink at 1-877-284-0102.
  - Occupational, speech or vision therapy, or any combination of these on an outpatient basis are covered up to the plan maximums if:
    - o Prescribed by a physician or in conjunction with a physician's services,
    - o Given by skilled medical personnel at home, in a therapist's office or in an outpatient facility,
    - o Performed by a licensed speech/language pathologist or audiologist, and
  - The following therapy services are not covered:
    - o Therapies to maintain or prevent deterioration of the patient's current physical abilities; and
    - o Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy.
- Habilitation Services/Therapies. There is a maximum of 30 visits combined in home, office or outpatient facility per calendar year for both in and out-of-network services combined. Precertification Required. Please contact HealthLink at 1-877-284-0102.

- Durable Medical Equipment, Medical Supplies. Orthotics, Prosthetics and Nutritional Supplements (enteral formulas and modified solid food products). The Fund will pay for the rental of such equipment, unless it is more economical to purchase it. The Fund also covers replacement of covered medical equipment because of wear, damage or change in patient's need, as determined by the treating physician.

  Examples of these services are:

  – Supportive devices essential to the use of an artificial limb;

  – Corrective braces;

  – Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors;

  – Nutritional Supplements for modified solid food products;

  – Disposable medical supplies such as syringes;

  – Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:

    o The formula is medically necessary and effective, and

    o Without the formula, the patient would become malnourished, suffer from serious physical disorders or die.

    o Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare provider must provide a written order.

  Also included are diabetes supplies prescribed by an authorized provider, blood glucose monitors, including monitors for the legally blind, testing strips, injection aids, cartridges for the legally blind and insulin pumps. Precertification Required for Durable Medical Equipment, Orthotics and Prosthetics. Contact HealthLink at 1-877-284-0102.

  The following equipment not covered under this benefit are, air conditioners or purifiers, humidifiers or dehumidifiers, exercise equipment, swimming pools, false teeth, hearing aids.

- Outpatient Treatment of Alcohol and Substance Abuse Benefit. The Plan will pay for outpatient treatment of alcohol and substance abuse. You pay only a $20 copayment per visit.

- Outpatient Mental Health Benefit. The Plan covers outpatient treatment of mental and nervous disorders. You pay only a $20 copayment per visit.

- Chiropractic Benefit. Benefits. The Fund pays 50% of the Anthem allowance for physician services in connection with the detection and correction by manual or mechanical means of structural imbalance,

distortion or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column are covered. There is a maximum of 50 visits per calendar year for both in and out-of-network services combined.

- Dental Services limited to surgical removal of impacted teeth, treatment due to an accidental injury to sound natural teeth that happens within twelve (12) months of accident and treatment of Amelogenesis Imperfecta.

In-Network Hospital & Medical Exclusions and Limitations

In addition to the exclusions noted under a specific benefit, please see the General Plan Exclusions section on pages 72 –73.

OUT-OF-NETWORK MEDICAL BENEFITS

Benefits are only payable under one category of benefits depending on whether the provider of services participates with Anthem. Out-of-Network Medical Benefits will not be processed and paid as an In-Network Benefit, except the PAARE benefit described below. There will be no duplication of benefits and covered services are payable as either an In-Network benefit or an Out-of-Network benefit, not both.

Deductible & Benefits Payable

You must meet the annual deductible prior to any benefit being paid. The annual deductible is the first $500 of eligible expenses incurred by the individual during the calendar year. The annual family deductible is $1,000 of eligible expenses. The family deductible is calculated on an aggregate basis, which means all eligible charges incurred by covered family members are combined to calculate the family deductible. Once the family deductible is met, all remaining family members will be deemed to have met their deductible from that date forward for the remainder of the calendar year without any additional deductibles being applied.

Once the annual deductible is met, the Plan will pay 70% of the usual and customary charges for covered services. You must pay the other 30% of the usual and customary charges, up to when your eligible out-of-pocket expenses reach the out-of-network out-of-pocket maximum. Once the out-of-network out-of-pocket maximum is met, the Plan pays 100% of the usual and customary charges. You are responsible for the difference between the Plan's payment and the provider's charge.

Common Accident Provision

If two (2) or more covered family members are injured in the same accident, only one yearly deductible will be charged to their combined eligible expenses due to the accident.

Out-of-Pocket Maximum

The out-of-network out-of-pocket maximum is $2,900 per individual; $5,900 per family. Once an individual reaches his/her out-of-pocket maximum, no further copayments or coinsurance will apply to that individual for the remainder of that calendar year. The family out-of-pocket maximum is aggregated for all family members. Once the family out-of-pocket maximum is met, the Fund's payments increase to 100% of the usual & customary charges for eligible services and supplies and your coinsurance (the 30%) stops for the remainder of that calendar year.

IMPORTANT NOTE: Regardless of whether you have met the out-of-pocket maximum, you will still be responsible for the difference between the Fund's payment and the billed charges. Non-participating providers are not required to accept the Fund's payment for services rendered.

Hospital Based Provider "PAARE" Benefit

The following claims for services by Out-of-Network providers will be processed using the In-Network rules regarding coinsurance, deductibles and out-of-pocket maximums:

- Pathology Interpretations, when (1) the underlying service is received in the emergency department of a hospital and (2) an emergency room visit is payable under Plan guidelines or (1) when the underlying service is performed by an in-network physician/laboratory or in-network facility.
- Anesthesiology services, when (1) the surgeon performing the procedure is an in-network provider and (2) the facility where the procedure is being performed is an in-network facility (whether it is a hospital or free-standing ambulatory surgical facility).
- Emergency land ambulance service to the nearest acute care hospital when provided by a licensed ambulance service. Such service must be (1) in connection with emergency room care or an emergency inpatient admission and (2) ordered by law enforcement or when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
  (a) 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
  (b) serious impairment to a person's bodily functions;
  (c) serious dysfunction of any bodily organ or part of a person; or
  (d) serious disfigurement to the member.

  Benefits are not available for transfers between healthcare facilities, unless otherwise noted.
- Radiology Interpretations, when (1) the underlying imaging service is received in the emergency department of a hospital and (2) an emergency room visit is payable under Plan guidelines or (1) when the underlying imaging service is performed by an in-network physician/laboratory or in-network facility.

- Emergency Room Physicians, when (1) the physician is not an employee of the hospital and (2) an emergency room visit is payable under Plan guidelines (includes emergency surgery performed by the ER physician in the ER).
- Inpatient Physician Services received from an out-of-network provider while confined in a participating facility when (1) the patient is admitted through the emergency room of the facility; (2) the provider had performed services to the patient in the emergency room of the same participating facility; (3) the only providers available at the time of the initial services were out-of-network; and (4) the provider is performing additional services to the patient.

The allowed amount for the above Out-of-Network services will be based upon the Fund's usual and customary fee schedule, not the amount billed by the provider.

ALL OTHER OUT-OF-NETWORK CLAIMS WILL BE PAID UNDER THE OUT-OF-NETWORK RULES REGARDING DEDUCTIBLE, COINSURANCE, COPAYMENTS AND OUT-OF-POCKET MAXIMUMS.

COVERED OUT-OF-NETWORK SERVICES

Inpatient Treatment of Alcohol and Substance Abuse Benefit

The Plan will pay for charges incurred during an inpatient confinement in a facility licensed by the appropriate State Agency. All inpatient confinements must be precertified through the Long Island Council on Alcoholism and Drug Dependence (LICADD). Contact LICADD at 1-516-747-2606.

Physicians' Services for the Treatment of Illness or Injury

Outpatient and inpatient surgery, (inclusive of the surgeon and anesthesiologist & including requirements under the Women's Health and Cancer Rights Act of 1998), home, office and hospital physician visits, and other medical care and treatment and, in the case of an elective surgical procedure, a second surgical opinion.

Preventive Care Services

This Fund provides coverage for certain preventive services as required by The Patient Protection and Affordable Care Act of 2010 (ACA). Out-of-network preventive services that are identified by the Fund as part of the ACA guidelines are covered at the same cost-sharing level as all other out-of-network services. This means that eligible services will be covered at 70% of the Fund's allowable charge, after the satisfaction of the deductible, until the out-of-network out-of-pocket maximum is met. Once the out-of-network out-of-pocket maximum is met, eligible services will be covered at 100% of the Fund's allowable charge. You will be responsible for the difference between the Fund's payment and the billed charges.

Preventive Services Coverage Limitations and Exclusions

- Preventive Services are covered when performed for preventive screening reasons <u>and</u> billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
- Services covered under the Preventive Services benefit are not also payable under other portions of the Fund.
- The Fund will use reasonable medical management techniques to control costs of the Preventive Services benefit. Specifically, the Fund will only cover the most cost-effective test methodology for all preventive tests and services on this list.
- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications).

- Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.
- Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Fund.
- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  - When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
  - When related to judicial or administrative proceedings;
  - When related to medical research or trials, except where required by Federal Law; or
  - When required to maintain employment or a license of any kind.
- Services related to male reproductive capacity, such as vasectomies and condoms, are not covered.

Diagnostic Laboratory and Imaging Services

The Fund provides out-of-network diagnostic laboratory and imaging services when ordered by a Physician for diagnosis and treatment of a covered illness or injury. Precertification is required for MRIs/MRAs, nuclear cardiology services and PT/CT scans. Contact HealthLink at 1-877-284-0102.

Nursing Care

Private duty nursing by a registered nurse (R.N.) or licensed practical nurse. This benefit is limited to a maximum of 30 days during any one period of illness. Precertification is required. Contact HealthLink at 1-877-284-0102.

Outpatient Rehabilitative Therapies (Physical, Speech, Orthoptic & Occupational)

Therapeutic services by a licensed and qualified therapist when related to a covered illness or injury. Orthoptic therapy is allowed when performed by an Ophthalmologist or Optometrist to treat diagnosed visual dysfunctions. Such therapies must be to restore loss of or improve functionality within a reasonable time. **No benefits are payable for services/therapies designed to prevent bodily deterioration.** There is a maximum of 30 visits per calendar year for both In and Out-of-Network services combined. Precertification is required. Contact HealthLink at 1-877-284-0102.

Outpatient Habilitative Therapies (Physical, Speech & Occupational)

Therapeutic and health care services designed to help a person keep, learn or improve skills and functioning for daily living. An example is speech therapy for a child who has delayed speech. Such treatment must be performed by a licensed and qualified therapist or licensed practitioner. There is a maximum of 30 visits per

calendar year for both In and Out-of-Network services combined. Precertification is required. Contact HealthLink at 1-877-284-0102.

Durable Medical Supplies and Prosthetic Devices

Blood and blood products; electronic heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches; rental of wheel chair, hospital bed, iron lung or other durable medical equipment for therapeutic use, oxygen and rental of equipment for its administration; non-dental prosthetic appliances such as artificial limbs, larynx and eyes, and dental prostheses replacing accidentally injured natural teeth within 12 months of the accident or necessary due to Amelogenesis Imperfecta. The Fund reserves the right to purchase rather than rent any supply. Precertification is required. Contact HealthLink at 1-877-284-0102.

The following equipment is not covered under this benefit: air conditioners or purifiers, humidifiers or dehumidifiers, exercise equipment, swimming pools, false teeth, hearing aids.

Outpatient Treatment of Alcohol and Substance Abuse Benefit

The Plan covers outpatient treatment of alcohol and substance abuse.

Outpatient Mental Health Benefit

The Plan covers outpatient treatment of mental and nervous disorders.

Home Health Care Expenses

Precertification required. Contact HealthLink at 1-877-284-0102.

This benefit covers for eligible charges for care furnished by a home health care agency licensed in New York State or the state in which the patient resides. The benefit is subject to the following conditions:

1. The patient is under the care of a physician who submits a “home health care plan” (a written program for care and treatment in the patient’s home and is medically necessary and certification that inpatient confinement in a hospital, convalescent nursing home or a skilled nursing facility would be required if the home care were not provided);

2. The care is furnished in New York State or the state in which the patient resides, and

3. The physician certifies that an inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if it were not for the home health care.

The eligible charges are the charges made by the agency for the following services and supplies ordered by the physician under the home health care plan and furnished in the patient's home:

4. Part-time or intermittent nursing provided or supervised by a registered nurse (R.N.).

5. Part-time or intermittent home health aide services.

6. Rehabilitative therapy (physical, occupational or speech) by a licensed, qualified therapist.

7. Medical supplies and equipment and medications prescribed by a physician and the medications prescribed, if the medications are not covered under the Prescription Drug Plan.

8. Laboratory services by or on behalf of a home health care agency, to the extent these services and supplies would have been covered if furnished by a hospital or a skilled nursing facility to an inpatient.

Under this benefit there is a maximum of 40 home health care visits per calendar year. Each visit by each member of a home health care team, other than a home health aide, is counted as one (1) visit. Each four (4) hours of service provided by a home health aide is considered one (1) visit.

Custodial services that do not require skilled care are not covered.

Chiropractic Benefit

Benefits for physician's services in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column are covered. The Fund will reimburse 50% of usual and customary charges, after satisfaction of the yearly deductible, up to a maximum of 50 visits in a calendar year for both in and out-of-network services combined.

Mouth Conditions

The Out-of-Network medical benefit covers limited mouth conditions. This benefit is available only for the treatment of malignant tumors, treatment of Amelogenesis Imperfecta and necessary dental services caused by an accident while the patient is covered. Any dental services caused by an accident must be rendered within 12 months of the accident causing the need for dental services. All other dental treatment is covered under the Dental Benefit.

ANNUAL MEDICAL EXAMINATION BENEFITS

In addition to the In-Network and Out-of-Network Preventive Care Benefits, the Plan covers an annual medical examination through the Professional Evaluation Medical Group ("PEMG"). Only one annual medical examination is allowed for each specific type of examination. For example, if you have an annual physical examination under the Preventive Care Benefit with an Anthem or Out-of-Network provider, you cannot then have another through PEMG.

<u>Only Participants and their spouses covered for medical benefits are eligible to receive the annual physical examination through PEMG</u>. To avail yourself of this examination, simply call PEMG at 516-935-4378 and arrange for a medical examination.

The medical examination may consist of the following components:

- **Review of Medical History** reviews past medical problems and present lifestyle
- **Complete Physical Exam** reviews all body systems
- **Vision and Hearing Tests** detect possible need for glasses or any hearing loss
- **Blood Chemistry Tests** which can evaluate kidney and liver functions, and the risk of coronary artery disease by reviewing total cholesterol, lipids, triglycerides, and screens for diabetes and gout
- **CBC** (Complete Blood Count) tests for anemia, infection, leukemia or blood abnormalities
- **Urinalysis** tests for kidney and bladder problems
- **Stool Examination** for Occult Blood detects the presence of hidden "occult" blood which may be a sign of colonic polyps or cancer
- **Full written medical report**.

Age Specific Tests

Examples of tests provided for under this benefit are as follows:

Electrocardiogram (35 years & older) checks electrical activity of heart and any irregularities.

Digital Rectal (40 years & older) detects cancer of the prostate.

Prostate Specific Antigen (PSA) (50 years & older) detect cancer of the prostate.

For Women

- Pap Test (29 & older) detects possible cervical cancer.
- Pelvic Examination detects gynecological problems.

Additional tests

The Plan covers these when medically indicated:

- Chest X-Ray determines condition of lungs, heart and spine.
- Pulmonary Function Test determines breathing capacity.

PRESCRIPTION DRUG BENEFIT

The U.F.C.W. Local 1500 Welfare Fund contracts with Express Scripts, Inc. (ESI) to administer your prescription drug coverage. The Fund's prescription drug benefit offers you coverage for your medications in two ways: one via a retail pharmacy and the other via a mail order service. The Plan allows for up to the greater of (1) a 34 day supply or (2) 100 units of medication to be filled at a retail pharmacy (provided these limits are within the drug quantity maintenance guidelines) and up to a 3 month supply of medication to be filled via the mail order service. The benefit covers medically necessary outpatient prescription medications and/or products that have been approved by the FDA and that can be dispensed only pursuant to a prescription order or refill, under State and Federal law. All prescriptions must be written and ordered by a provider licensed and authorized to prescribe medications and within the provider's scope of practice. All prescriptions must be within the approved FDA administration and dosing guidelines and must be dispensed by a licensed pharmacy. A prescription drug includes a medication that, due to its characteristics, is appropriate for self-administration. The Plan also covers needles and syringes on prescription when purchased in connection with insulin and/or diabetic medication or a life threatening illness or condition (i.e. EpiPen for allergies). The Plan does not cover drugs which may legally be dispensed without a prescription, such as aspirin or vitamins, unless eligible under the Preventive Care Benefit. Additionally, for certain Preventive Care immunizations, the Plan will allow coverage through the prescription drug benefit

There is no limit to the number of prescriptions that may be purchased through the Plan. Each prescription or refill must be for a stated amount of medication and must be for no more medication than is necessary for the treatment of the medical condition. If your physician authorizes, each prescription may be refilled up to five (5) times within six (6) months of the date the original prescription was written.

The Fund's Prescription Drug Benefit offers you coverage for your eligible medications in two ways: one via a retail pharmacy and the other via a mail order service.

You will receive an ID card, from Express Scripts, Inc. (ESI) showing your eligibility for prescription drug benefits through the Fund.

The Prescription Drug Benefit is a three (3) tier formulary program. A formulary is a list that identifies those prescription drugs for which coverage may be available. This list is subject to periodic review by ESI and the Trustees. Under this benefit, medications are divided into three (3) categories: generic drugs; preferred brand name drugs; and non-preferred brand name drugs or specialty drugs. The classification of any drug is approved by the Trustees based upon the ESI's clinical determination of effectiveness.

If you have any questions about whether the medication you are prescribed is a generic, preferred brand name or non-preferred brand name medication or specialty drug, please contact Express Scripts, Inc. at www.Express-Scripts.com or the Express Scripts Customer Service Department at 1-877-861-8145.

Utilization Management

The Plan's Prescription Drug Benefit includes a Utilization Management (UM) program. The UM program consists of 3 components:

1. Prior Authorization of Medications
2. Step Therapy
3. Drug Quantity Maintenance

Prior Authorization

Prior Authorization (PA) is a program that monitors certain prescriptions for safety and cost. PA reviews are done before the medication is dispensed to ensure the necessity of the drug.

The Prior Authorization program works as follows: when your pharmacist tries to fill a prescription, the computer system will indicate "prior authorization required". This means that information is needed to determine if the Plan covers the drug. You can then ask your doctor to contact Express Scripts or prescribe another medication that does not require Prior Authorization. Express Scripts Prior Authorization phone lines are open Monday – Friday, 8am to 9pm Eastern Time. The number to call is (800)417-1764.

If the information is deemed appropriate, Express Scripts will allow the medication to be processed. Thereafter, you only pay the applicable copayment at the pharmacy. If the medication is not deemed appropriate, it will not be covered and your physician has the option of prescribing another medication. If a medication is not deemed appropriate, you may choose to fill it anyway, but you will be responsible for the full cost of the drug.

To obtain prior authorization, ask your doctor to call Express Scripts at 1-800-417-1764, Monday – Friday 8 AM to 9 PM Eastern Time, to arrange a review. **If your doctor does not call and get approval, you will be responsible for the full cost of the medication.**

If you have any questions as to whether or not a medication being prescribed by your doctor requires prior authorization, contact Express Scripts Customer Service Department at 1-877-861-8145.

Step Therapy

Step Therapy is a program for people who take prescription drugs regularly to treat a medical condition such as arthritis, asthma or high blood pressure. It allows you to receive the affordable treatment you need while helping the Plan contain costs.

Step Therapy medications are grouped into categories based upon treatment and cost. The categories are:

- Front-line drugs – the first step. These drugs are generic and sometimes lowest-cost brand drugs proven to be safe, effective and affordable. In most cases, you should try these drugs first because they provide the same health benefit as a more expensive drug at a lower cost.
- Back-up-drugs – step 2 and step 3. These are brand name drugs that are generally necessary for only a small number of patients.

The Step Therapy program works as follows: the first time you submit a prescription that is not for a front-line drug; your pharmacist will inform you that, unless you wish to pay the entire cost of the prescription, you need to try a front-line drug first. To receive a front-line drug, ask your pharmacist to call your doctor and request a new prescription or contact your doctor to get a new prescription.

PLEASE NOTE: Only your doctor can change your current prescription to a first-step drug covered by this program.

If you have already been taking a medication regularly and you need the medication immediately, you can ask the pharmacists to contact your doctor for a new prescription for a front-line medication or you can discuss with the pharmacist the possibility of filling a small quantity of the medication you have been taking. However, you might have to pay the full cost of that medication. Thereafter, to ensure your medication will be covered by the Plan in the future, ask your doctor to write a new prescription for a front-line drug.

If you cannot take a front-line drug, under step therapy, a more expensive brand-name medication is usually covered as a back-up, provided that you meet the following 3 criteria: (1) you have already tried the generic drug covered under the step therapy program, (2) you can't take the generic drug (for example, due to an allergy) and (3) your doctor decides, for medical reasons, that you need a brand-name medication.

If one or more of these situations applied to you, your doctor can contact Express Scripts and request an "override" or an authorization to allow you to take a back-up drug or another alternative.

The Plan's Step Therapy program applies to both Retail and Mail Order.

Drug Quantity Management

Drug Quantity Management (DQM) is a program that is designed to make use of prescription drugs safer and more affordable. It provides medication you need while making sure you receive it in the amount (or quantity) considered safe.

There are certain medications in this program. For those medications, you may only receive a specified amount. The quantity dispensed allows you to receive medication (1) in the daily dose considered safe and effective by the U.S. Food & Drug Administration (hereinafter "FDA") (i.e., for a medication you take once a

day, the Plan will allow you to fill a prescription for 30 pills/capsules) and/or (2) in a more cost effective manner (i.e., if a prescription is available in different strengths, sometimes you can take a higher strength pill rather than 2 smaller strength pills). In that way, you would have one copayment instead of two.

DQM works as follows: When you submit your prescription, your pharmacist's computer system will note that the prescription is for a non-covered amount of medication. This could mean that you have asked for a prescription too soon or your doctor wrote the prescription for a quantity larger than the Plan covers.

If the quantity on your prescription is too large, you can ask the pharmacist to fill the prescription as written, but for the amount allowed under the DQM guidelines. You will pay the appropriate copayment. This may mean you will have to fill the prescription more frequently which, in turn, could end up costing you additional copayments or you can ask the pharmacist to contact your doctor to discuss changing the prescription (for example, if the issue is the strength of the medication and your physician is prescribing a low dosage medication, the pharmacist and doctor can discuss the possibility of having a higher strength medication dispensed) or your doctor can contact Express Scripts and request a PA for the medication as written. If the request is denied, you can still get the medication, however, it will be dispensed in the quantity recommended by the DQM. In those cases, you will continue to pay the Plan's copayment each time you get a refill.

The DQM program applies to the Plan's retail and mail order options.

In mail order cases, Express Scripts will try to contact your doctor to suggest either changing your prescription or asking for a PA. If your doctor is unavailable at the time Express Scripts contacts him/her and Express Scripts does not hear from him/her within 2 days, Express Scripts will fill your prescription for the quantity covered under the DQM.

PLEASE NOTE: The DQM program does not deny you access to your needed medication. It simply ensures that the Plan provides the prescription drugs you need in the quantities that follow the Plan's guidelines for safe and economical use, as determined by the FDA.

Prescription Drug Benefit Co-Payment

The Prescription Drug Benefit has a three (3) tier copayment depending on the formulary classification of the medication received (generic, preferred brand name drugs and non-preferred brand name drugs or specialty drugs) and the manner in which the prescription is filled (i.e. retain pharmacy or mail order).

RETAIL PHARMACY COPAYMENT

The copayment structure for medications received at a retail pharmacy is as follows: For generic medications, you pay 20% coinsurance, up to a maximum of $10 per prescription. For preferred brand name medications, you pay 20% coinsurance, up to a maximum of $25 per prescription. For non-preferred brand

name medications or specialty medications, you pay 20% coinsurance up to a maximum of $50 per prescription. The Plan allows for up to a 34 day supply of medication to be filled at retail.

Mail Order Pharmacy Copayment

The copayment structure for medications received via ESI mail order is as follows: For generic medications, you pay 20% coinsurance, up to a maximum of $20 per prescription. For preferred brand name medications, you pay 20% coinsurance, up to a maximum of $50 per prescription. For non-preferred brand name medications or specialty medications, you pay 20% coinsurance up to a maximum of $100 per prescription. The Plan allows up to a 3 month supply of medication to be filled via the mail order service.

Prescription Drug Benefit Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay for expenses during the calendar year before the Fund begins to pay 100% of the ESI fee schedule allowance. The In-Network out-of-pocket maximum is $400 per individual, $800 per family. The Out-of-Network out-of-pocket maximum is $1,100 per individual, $2,100 per family. To calculate the family out-of-pocket maximums, one individual must first meet his/her out-of-pocket maximum and then from that date forward, the family out-of-pocket maximum is calculated on an aggregate basis for all family members. When the respective out-of-pocket maximum is reached, the Fund's payments increase to 100% of the Express Scripts allowance for eligible services and supplies and your copayments stops for the remainder of that calendar year.

PLEASE NOTE: If you receive a brand name medication when there is a generic equivalent, you must pay the difference between the generic reimbursement level and the brand name reimbursement level.

Obtaining Your Medication

A) Obtaining Your Medication through a Retail Pharmacy

1) Benefits Through Participating Pharmacies

Most of the pharmacies in your community participate in the Express Scripts, Inc. network. If your pharmacist does not participate, urge him/her to join Express Scripts, Inc. If you cannot find a participating pharmacy in your neighborhood, go to www.ExpressScripts.com to locate a participating pharmacy or contact Express Scripts, Inc. Customer Service at 1-877-861-8145.

You will receive an ID card, from Express Scripts, Inc. (ESI) showing your eligibility under for prescription drug benefits through the Fund. Present the Fund's Express Scripts, Inc.'s prescription drug benefit identification card to the pharmacist with the prescription to be filled.

You will be required to pay the respective copayment when receiving your medication.

2) Direct Reimbursement Benefits (Non-Participating Pharmacies)

If, for any reason, you cannot fill your prescription at a participating pharmacy or use your identification card, you will have to use a direct reimbursement claim form. You will have to contact Express Scripts, Inc. for a claim form. The claim form, along with receipts showing the medication received and your payment, must be sent to Express Scripts, Inc. for direct payment. You will have to pay the pharmacist and you will be reimbursed on the basis of what would have been paid to the pharmacy if your card had been used at a participating pharmacy, less the appropriate copayment. You should be aware that in most cases this will be less than the price you paid to the pharmacy.

IMPORTANT NOTE: THE FOLLOWING PHARMACIES ARE NOT PARTICIPATING PROVIDERS AND ARE EXCLUDED FROM COVERAGE. NO BENEFIT WILL BE PAID FOR ANY SERVICES OR PRESCRIPTIONS DISPENSED BY THEM UNDER ANY CIRCUMSTANCES.

B.J.'s Pharmacies	Costco Pharmacies
K-Mart Pharmacies	Target Pharmacies
Wal-Mart Pharmacies	Walgreen Pharmacies
Sam's Pharmacies	Hannaford Brothers
CVS Pharmacies	Price Chopper

If your physician or pharmacist has any questions regarding the prescription drug benefit, please have him/her contact the Express Scripts, Inc. Pharmacy Services Help Desk number at 1-800-922-1557.

B) Obtaining Your Medication through Mail Order

If you have a chronic condition (long term illness) and require the same medication for a long time (e.g. diabetic medications, heart condition medications, high blood pressure medications, etc.) you can obtain up to a 3-month supply of medication, at one time, through the ESI mail order. No medications for acute conditions (such as an antibiotic) may be filled through the mail order.

Drugs purchased through the mail order are delivered directly to your home or office.

Your doctor should issue a prescription for at least a 90 day supply and the prescription must indicate the dosage and number of months to be used (maximum 6 months). Only one (1) refill is permitted under the mail order program. A new prescription is required for each order after the 6 month period, with the exception of controlled substances. Where controlled substances are required, a 30 day supply will be mailed in accordance with the prescription and applicable laws.

Mail the prescription, along with the maintenance medication claim form (obtainable through Express Scripts) to:

Express Scripts, Inc.
PO Box 747000
Cincinnati, OH 45274-7000

Prescription Drug Benefit Exclusions

Along with all other Plan exclusions, the Prescription Drug Program does not cover the following expenses.

a) Drugs dispensed without a prescription or drugs which can be purchased without a prescription even though a doctor may prescribe it (such as aspirin or vitamins), unless covered under the Preventive Care Services or mandated by the Affordable Care Act ("ACA").

b) Blood or blood plasma.

c) Any medication which is to be taken by or administered, in whole or in part, to the eligible person while such person is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.

d) Any drug labeled, "Caution – Limited by Federal Law to Investigational Use," or experimental drugs even though a charge is made to the patient, unless part of a clinical trial mandated by ACA.

e) Routine immunizing agents, unless covered under the Preventive Care Benefit.

f) Drugs administered to an eligible person in the prescriber's office.

g) Hypodermic syringes and needles, unless prescribed and purchased in connection with insulin and/or injectable diabetic medications, such as Byetta pens and life threatening illness, such as an EpiPen for a life threatening allergy.

h) Administration charges for drugs or insulin.

i) Unauthorized refills.

DENTAL BENEFIT

The Plan provides benefits for eligible dental services when furnished by a licensed dentist while you and/or your dependent(s) are covered. You may choose any duly licensed dentist or dental surgeon. However, to assist you in getting the most for your benefit dollars, the Fund has contracted with Integrated Dental Administrators, Inc. and, as of January 1, 2019, the Fund has also contracted with DDS, Inc. to provide access to their networks of dental providers. Should you wish to use network dentists, go to the Fund's Website at www.ufcw1500.org to view the listing of both IDA and DDS, Inc. providers. You also may visit the DDS, Inc. website at www.ddsinc.net to locate a participating DDS, Inc. provider near you or in the specialty you need. At any time, you may contact the Fund Office to locate a provider nearest to you. Again, you are not required to utilize these networks.

The Benefits

The Fund will pay the fee the dentist charges for covered dental services, up to the maximum allowable amount shown in the Schedule of Dental Procedures appearing later in this booklet.

The maximum dental benefit during any calendar year for you and your dependents will not exceed the calendar year maximum shown in the Schedule of Benefits. See page 22.

Please note the following:

- A charge will be considered to be incurred on the date the service is performed or the supply is furnished, not on the date the bill is received by the Fund.
- If a patient is transferred from one dentist to another in the course of treatment or if more than one dentist renders service on the dental procedure, the benefits will be determined just as though one dentist had furnished all treatment.

Pre-Determination of Benefits

For services estimated to be over $500 you and/or your covered dependents are required to have your dentist submit the proposed course of treatment ("Treatment Plan"), unless treatment is provided on an emergency basis. A Treatment Plan is not required to be submitted if the charges are not expected to exceed $ 500.

A Treatment Plan is the dentist's report that (a) itemizes his/her recommended services/supplies (complete with tooth number and ADA coding), (b) shows his/her charge for each service and (c) is accompanies by supporting x-rays.

"Pre-Determination of benefits" permits resolution of a course of treatment before services are rendered. Both you and the dentist will be advised, in advance of what is covered and estimated amount the Fund will pay for those covered services. Of course, you and/or your eligible dependent must be covered by the Plan on the date services are performed regardless of any pre-determination.

If a Treatment Plan is not submitted to the Fund, the Fund reserves the right to decide the benefits payable at the time the claim is submitted, taking into account alternate procedures, services or courses of treatment based upon accepted standards of dental procedures. In computing the estimated benefits, the Fund may consider alternate dental services that are suitable for treatment of a specific condition. This will be done only if those alternative services would produce a professionally acceptable result, as determined by the Fund.

Extended Benefits

If your coverage terminates, dental benefits will be extended for three months for a procedure or series of treatments already started at the time coverage otherwise terminates, provided benefits would have been payable had coverage continued.

Exclusions

Along with all General Plan Exclusions, the Dental Benefit does not cover:

1. Services or supplies (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.
2. Anything not ordered by a dentist; anything not necessary for dental care; or services deemed experimental or not accepted by the American Dental Association standards of dental practices; charges in excess of those usually made when there is no insurance or other coverage or in excess of the usual and customary charges in the geographic area.
3. Expenses due to war (including undeclared war and armed aggression).
4. Expenses due to an accident related to employment or disease covered under Workers' Compensation, automobile coverage (including but not limited to "No Fault insurance") or similar law.
5. Orthodontics (a program to straighten teeth), except as noted. See the Orthodontic Benefit on pages 68-69.
6. Expenses for crowns or appliances if made solely for periodontal involvement and to stabilize or splint mobile teeth.
7. Expenses for replacement of a lost prosthetic appliance.
8. Fees for the replacement of any full or partial dentures, fixed bridgework or crowns if benefits for these appliances had previously been provided under the dental benefit, unless three (3) years have elapsed from the installation of any such appliances. This exclusion also applies to the replacement of a prosthetic appliance by fixed bridgework within a three year period. However, if an immediate (temporary) denture, for which the charge was less than the allowance in the schedule, is replaced by a permanent denture within a three (3) year period, the Fund will pay the difference between the scheduled allowance for the permanent denture and the charge for the immediate (temporary) denture.

9. Fees for removable partial maxillary or mandibular replacement with a partial denture, unless three (3) or more permanent teeth are missing from either the right or left quadrants of the maxilla or mandible.
10. Services and supplies solely for cosmetic purposes.
11. Dental implants and related charges & attachments, including but not limited to crowns over implants.
12. Provisional or temporary crowns. These are considered included within the allowance for a permanent crown

Integrated Dental Administrators, Inc. (IDA) & DDS, Inc. Copayments

The dentists on the IDA and DDS, Inc. panels will accept the Fund's reimbursement as payment in full for most services. However, there are copayments for certain procedures.

The following are copayments you may be charged when you receive certain services from any IDA or DDS, Inc. provider:

Procedure	Total Fee	Plan Payment	Member Copayment
Prosthodontic Services			
Maryland Bridge Retainer	$220.00	$170.00	$ 50.00
Metallic Inlay 1 Surface	100.00	80.00	20.00
Metallic Inlay 2 Surface	150.00	100.00	50.00
Metallic Inlay 3 Surface	200.00	120.00	80.00
Oral Surgery			
Panorex Film	$ 52.00	$ 42.00	$ 10.00
Partial Bony Impaction	175.00	110.00	65.00
Complete Bony Impaction	220.00	110.00	110.00
Cystectomy	120.00	72.00	48.00
Incision and Drainage	50.00	30.00	20.00
Apicoectomy: 1Root	220.00	108.00	112.00
Apicoectomy: 2 Roots	335.00	216.00	119.00
Apicoectomy: 3 Roots	450.00	324.00	126.00
Periodontic Services			
Osseous Surgery	450.00	300.00	150.00
Mucogingival Surgery	350.00	108.00	242.00

Neither the Fund nor the Trustees have a financial interest in or control over IDA or DDS, Inc., and, therefore, assumes no liability for damages incurred by using a provider associated with these networks.

DENTAL EXPENSE BENEFITS
SCHEDULE OF DENTAL PROCEDURES

EXAMINATIONS, PROPHYLAXES AND X-RAY	MAXIMUM PAYMENT
Examination and charting Maximum: Twice during any 12 month period	$ 18.00
Prophylaxis Maximum: Twice during any 12 month period	18.00
Topical application of fluoride* Maximum: Twice during any 12 month period	12.00
14 Standard X-rays or panorex X-ray Maximum: once during any 12 month period if performed by a different dentist (once during any 36 month period if performed by the same dentist)	42.00
4 Bitewing X-rays Maximum: Twice during and 12 month period	11.40
Intra-oral film, occlusal view (in lieu of standard X-rays, endentulous jaws) Maximum: one each jaw during coverage, each film	2.85
Tempromandibular joint film	14.40
Anterior-posterior film, head and jaws	10.00
Lateral film of head and jaws	8.00

*Effective on and after January 1, 2016, preventive care for children will include application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

EXTRACTIONS

Procedure	Maximum Payment
Impacted teeth: Upper third molars, each	$ 110.00
Other than upper third molars, each	110.00
Deep Sedation/General Anesthesia* - 1st 30 minutes	75.00
Deep Sedation/General Anesthesia* - Additional 15 minute increments	45.00
Inhalation of Nitrous Oxide, anxiolysis*	50.00
Intravenous conscious sedation* - 1st 30 minutes	75.00
Intravenous conscious sedation* - Additional 15 minutes increments	45.00
Intravenous moderate conscious sedation* - Each 15 minute increment	50.00
Non-intravenous conscious sedation*	50.00

*The anesthesia benefits noted above are available ONLY FOR extractions of impacted wisdom teeth

Procedure	Maximum Payment
Malposed tooth (demonstrated by X-ray) A tooth having markedly enlarged roots requiring bone removal	72.00
Surgical extractions (sutures included)	110.00
Routine extractions, each tooth	40.00

	MAXIMUM PAYMENT
FILLINGS	
Per Surface	$ 22.00
Maximum per tooth	60.00
Gold or porcelain inlays (as substitutes for fillings)	
One Surface	96.00
Two Surfaces	120.00
Three or more surfaces: Maximum: one tooth	144.00
Retrograde filling	24.00
PALLIATIVE	
Emergency visit for relief of pain	$ 30.00
PERIODONTIA	
For Service provided by a Dentist who is a Board Certified Specialist*:	
Root Scaling, prophylaxis, medication and minor bite correction:	
Each treatment	$ 43.00
Maximum in any 12 month period	430.00
Gingivectomy, each quadrant consisting of a minimum of 5 teeth	240.00
Gingivectomy, each quadrant consisting of less than 5 teeth	
Per tooth	43.00
Osseous Surgery	300.00
Placement of Antimicrobial Agents	50.00
For service provided by a Dentist who is not a Board Certified Specialist*:	
Root scaling, prophylaxis, medication and minor bite correction:	
Each treatment	$ 29.00
Maximum in any 12-month period	290.00
Gingivectomy, each quadrant consisting of a minimum of 5 teeth	108.00
Gingivectomy, each quadrant consisting of less 5 teeth	
Per tooth	22.00
Placement of Antimicrobial Agents	50.00

***A dentist who is certified to specialize in periodontia by the American Board of Periodontology will be deemed to be a Board Certified Specialist.**

	MAXIMUM PAYMENT
ORAL SURGERY (other than extractions)	
Fracture of jaw (if not covered by any other insurance issued under a group plan)	
Lower jaw, closed reduction	$ 132.00
Upper or lower jaw, open reduction	216.00
Removal of cysts, including necessary extractions	72.00
Cystectomy	72.00
Incision and Drainage	30.00
Retrograde Filling	24.00
Alveolectomy, maximum per jaw	$ 96.00
Biopsy	36.00
Closure of oral antral fistula	72.00
Removal of labial frenum	54.00
ROOT CANAL THERAPY	
Regular procedures as follows:	
Removal of pulp and filling canal	
First canal, per tooth	$ 192.00
Each additional canal, same tooth	96.00
Pulp capping, maximum per tooth	14.00
Apicoectomy, 1 Root	108.00
Apicoectomy, 2 Roots	216.00
Apicoectomy, 3 Roots	324.00
SPACE MAINTAINERS (Up to age 19)	
Acrylic	$ 72.00
Metal	90.00
BEDSIDE CALL (Home or Hospital)	30.00
DENTURES, Full or Partial	
Full, immediate or permanent, total for one or both, maximum Each jaw	$ 420.00
Partial, bilateral, chrome cobalt alloy or gold base, 2 or more full cast clasps with occlusal rests, acrylic attachments and porcelain or acrylic teeth, either jaw, each	420.00
Adding teeth to a partial denture to replace natural teeth not part of existing denture,	
First tooth	30.00
Each additional tooth	18.00
Obturator (not including denture)	72.00

DENTURES, Full or Partial

	MAXIMUM PAYMENT
Rebasing, one per denture per 3 year period	$ 90.00
Relining, one per denture per 3 year period	90.00
Metallic Inlay, 1 Surface	80.00
Metallic Inlay, 2 Surface	100.00
Metallic Inlay, 3 Surface	120.00

BRIDGEWORK, FIXED

Abutment crown or jacket	$ 375.00
Pontic	300.00
Maryland Bridge Retainer	168.00

JACKET CROWNS TO RESTORE TEETH

(When teeth are not repairable by fillings)

Anterior and Posterior Teeth	$ 375.00
Stainless steel crown	72.00

REPAIR OF PROSTHETIC APPLIANCES

Dentures, Acrylic

Repairing Body	$ 58.00
Replacing broken teeth, per tooth	30.00
Replacing broken teeth not requiring other repairs:	
First tooth	30.00
Each additional tooth	30.00
Replacing clasp, clasp intact	36.00
Replacing broken clasp with new clasp	60.00

The Fund will determine a consistent maximum payment for a dental procedure not listed, provided it is not excluded by the terms of the Plan.

ORTHODONTIC BENEFITS

The Plan provides the following benefits for orthodontic treatment (a program to straighten teeth) for a person who is less than age 19 on the date the treatment commences.

The benefit pays 100% of the eligible charges, up to the amount shown below and up to the maximum noted below.

However, to assist you in getting the most for your benefit dollars, the Fund has contracted with Integrated Dental Administrators, Inc. and, as of January 1, 2019, the Fund has also contracted with DDS, Inc. to provide access to their networks of dental providers. Should you wish to use network dentists, go to the Fund's Website at www.ufcw1500.org to view the listing of both IDA and DDS, Inc. providers. You also may visit the DDS, Inc. website at www.ddsinc.net to locate a participating DDS, Inc. provider near you or in the specialty you need. At any time, you may contact the Fund Office to locate a provider nearest to you. Again, you are not required to utilize these networks.

Predetermination of Benefits

An "Orthodontic Treatment Plan" is a report on a form satisfactory to the Fund that, among other things, describes the recommended treatment, gives the estimated charge and is accompanied by cephalometric X-rays, study models and other supporting evidence.

Eligible charges are charges for an orthodontic procedure that (a) is contained in an "Orthodontic Treatment Plan" that has been reviewed by the Fund prior to services being rendered and which has been returned to the dentist showing estimated benefits and (b) is required by an over bite of at least four millimeters, crossbite, or protrusive or retrusive relationship of at least one cusp.

The Benefits

For services provided by a Dentist who is a Board Certified Specialist*

Diagnosis and all orthodontic appliances	$ 252.40
Active treatment per month of treatment	72.00
Maximum 20 months	1,440.00
Passive treatment per six months of treatment	43.20
Maximum 18 months	129.60

For Services which are provided by a Dentist who is not a Board Certified Specialist*

Diagnosis and all orthodontic appliances	$ 72.00
Active treatment per month of treatment	29.00
Maximum 20 months	580.00
Passive treatment per six months of treatment	18.00
Maximum 18 months	54.00

A dentist who is certified to specialize in orthodontia by the American Board of Orthodontics will be deemed to be a Board Certified Specialist.

Maximum Orthodontic Benefit

For treatment made by a Board Certified Specialist, the maximum benefit is $1,822.

For treatment made by a Non-Board Certified Specialist the maximum benefit is $ 706.

Integrated Dental Administrators, Inc. (IDA) and DDS, Inc. Copayment

Below please find the patient copayment that pertains to services rendered by an In-Network, Board Certified Orthodontist.

Total Orthodontic Fee.. $2,400
Local 1500 Welfare Fund Reimbursement $1,822
Patient Copayment.. $ 578

Exclusions

Along with all General Plan Exclusions, the Orthodontic Benefit does not cover or limits coverage as follows:

1. If treatment is commenced before the patient became covered by this Plan, the maximum number of months of treatment provided by the Plan will be reduced by each month of active or passive orthodontic treatment rendered before the commencement of the patient's coverage by this Plan.
2. Anything not ordered by an orthodontist or deemed experimental or not accepted by the American Dental Association standards of dental practices; charges in excess of those usually made when there is no insurance or other coverage or in excess of the usual and customary charges in the geographic area.
3. Expenses due to war (including undeclared war and armed aggression).
4. Expenses due to an accident related to employment or disease covered under Workers' Compensation, automobile coverage (including but not limited to "No Fault insurance") or similar law.
5. Expenses for crowns or appliances, if made solely for periodontal involvement and to stabilize or splint mobile teeth.
6. Retainers, bite plates or removable appliances.
7. Expenses for replacement of a lost prosthetic appliance
8. A charge incurred while the patient's coverage is not in effect.
9. A charge that does not meet the requirements of an eligible charge, as defined.

ANY SERVICE OR SUPPLIES NOT SPECIFICALLY LISTED ARE NOT COVERED BY THIS BENEFIT

VISION CARE BENEFITS

In an effort to assist you in getting the most for your benefit dollars, the Fund has contracted with Vision Screening, Inc., General Vision Services, Inc. (GVS), Comprehensive Professional Systems, Inc. (CPS) and County Optical to provide access to their respective network providers. You are not required to use these networks and may choose any optical provider you wish and receive the benefits listed below. However, if you use an out-of-network provider, you will probably have higher out of pocket costs. Should you wish to use a provider associated with one of these networks, you can contact the Fund Office to locate a provider nearest to you. You can also visit the CPS website (www.cpsoptical.com), the Vision Screening website (www.vscreening.com) and the GVS website (www.generalvision.com) to locate a provider near you. Additionally, the GVS website provides you and your eligible spouse the option of going online to review your eligibility, schedule an appointment and view the frames available under the Plan.

Please be advised that neither the Fund nor the Trustees have a financial interest in or control over the above networks or their providers, and, therefore, assume no liability for damages incurred when you use a provider associated with this network.

Benefits are provided for covered eye examinations, eyeglass lenses, frames and contact lenses, up to the amount listed in the schedule below. Eye examinations must be performed by a duly licensed Optometrist, Optician or Ophthalmologist.

The Benefits

Eye Examination	**Maximum Payment**
Without Ophthalmological tests	$ 8.00
With Ophthalmological tests	16.00
Lenses	
Single vision lenses	$ 28.00
Bi-focal lenses	42.00
Tri-focal lenses	70.00
Lenticular lenses	166.00
Contacts	
Daily Wear (Vile) Contact lenses (in lieu of lenses and frames)	$ 100.00
Disposable Wear Contact lenses (in lieu of lenses and frames)	100.00
Contact lenses (medically necessary)	264.00
Frames	35.00

Maximum Payment for Lenses means the benefit is for two (2) individual lenses.

Exclusions

Along with all General Plan Exclusions, the Vision Care Benefit does not cover:

1. More than one eye examination in any 12 consecutive months.
2. More than two lenses in any 12 consecutive months.
3. More than one pair of frames in any 24 consecutive months.
4. Contact lenses, except as noted above.
5. Sunglasses, whether prescription or otherwise.
6. Replacement of lost, stolen or broken lenses or frames furnished under this coverage.
7. Eye examinations required (a) as a condition or employment which the employer is required to provide by a labor agreement and/or (b) by a government body.
8. Special medical procedures, such as orthoptic therapy or medical or surgical treatment of the eye. See the Medical Benefits noted earlier.
9. Service or supplies received as a result of an accident related to employment, or disease covered under Workers' Compensation, No Fault or similar law.
10. Services or supplies (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.
11. Anything not necessary for vision care.
12. Charges in excess of those usually made when there is no coverage or in excess of the general level in the area.
13. The portion of a charge paid under another part of this Plan.

GENERAL PLAN EXCLUSIONS

Along with all exclusions noted under a specific benefit, the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan does not cover:

1. Services or supplies received as a result of an accident related to employment, or sickness covered under Workers' Compensation or similar law.
2. Services or supplies (a) furnished by or for the U.S. Government; or (b) furnished by or for any other government, unless payment is legally required; or (c) to the extent provided under any governmental program or law under which the individual is or could be, covered, to the extent allowed by law.
3. Anything not ordered by a physician or not medically necessary and/or indicated; hospital charges to the extent they are determined to be for scholastic, education or vocational training (except as authorized by the Affordable Care Act); the portion of a charge for a service or supply in excess of the usual and customary charge (See pages 12-17).
4. Professional Services rendered by you, your spouse, your eligible dependent child and the brother, sister, or parent of either you or your spouse.
5. Injuries or illness sustained as result of an act of war, declared or otherwise.
6. Hearing aids and their related services.
7. Expenses in connection with cosmetic surgery. However, cosmetic surgery is not considered to include reconstructive surgery (a) which is incidental to or follows surgery for injury or disease to the involved party; (b) to correct a functional defect due to a congenital disease or anomaly of a covered child; or (c) for breast reconstruction performed pursuant to the Women's Cancer Rights Act of 1998.
8. Treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; (b) corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.
9. Expenses applied toward satisfaction of the deductible.
10. Expenses for "check-ups", immunizations and annual physical examinations, except as noted.
11. All prescription drugs, including self-administered injectables, oral medications, contraception (oral, injectable, patches & diaphragms) are covered under the Prescription Drug Benefit only.
12. Any resulting illness or injuries sustained by the covered person during a criminal act, including aiding and abetting the commission of a crime (excluding domestic violence).
13. Any resulting injuries sustained during participation in a riot or insurrection, whether or not such participation in a riot was a criminal act or committed while under the influence of alcohol, narcotics or other substances.

14. Charges covered and/or eligible under any motor vehicle policy, whether or not such policy is required by law, including but not limited to “No-Fault” coverage
15. No payment will be made for any assisted reproductive technologies, including but not limited to artificial insemination, in-vitro fertilization, gamete and zygote intrafallopian tube transfer, intracytoplasmic sperm injection or reversal of elective sterilization or gender change treatment.
16. Obesity, weight control programs and nutritional counseling or any other type of service for weight control, whether it relates to an illness or not, except as required under ACA.
17. Experimental or obsolete procedures and treatments. The Plan will not pay for any procedure if it is no longer generally regarded as effective (obsolete) or if it is experimental in the sense that its effectiveness is not generally recognized (except clinical trials required under the Affordable Care Act). The Trustees and/or their designated representatives will determine the effectiveness of any procedure.
18. Any injury or any resultant expenses incurred during any educational program (whether scholastic or vocational) and/or any organized sports or recreation program conducted by either a school, college or other social organization when insurance of any kind (medical or otherwise) exists through the program or social organization that would provide coverage for such injury or expense.
19. Dental treatment under hospital and medical benefits, except In-Network dental treatment made necessary by injury to natural teeth or a fractured jaw rendered within twelve months of the injury and In-Network surgical removal of impacted teeth and Out-of-Network dental services as noted.
20. No payment will be made for transplants of any kind including but not limited to organ, tissue, stem cell and bone marrow, unless prior authorization is obtained.
21. Cosmetic treatment, except for treatment of injury sustained in an accident occurring while the Participant is covered.
22. Expense for services or supplies to the extent that a third party may be liable for the person’s illness or injuries, without a signed Reimbursement Agreement. Please see pages, on pages 107-108 for details on the Fund’s Third Party Liability procedures.
23. Travel, even if associated with treatment and recommended by a physician.
24. Worksite screening services, as a condition of employment, performed at your place of work at no cost to you and governmental health department screening offered at no cost to you.
25. Injuries due to high risk activities. Such high risk activities are evaluated on a case by case basis to determine the likelihood of injury at the time the activity occurred.
26. Charges for obtaining medical records on behalf of the participant.
27. Charges for missed appointments.

PAYMENT SCHEDULE OF BENEFITS FOR PARTICIPANT ONLY BENEFITS

Group Term Life Insurance

During 1st year of employment* .... $ 5,000
After 1st year of employment* $30,000

Group Accidental Death and Dismemberment Insurance **Principal Sum**

During 1st year of employment* .... $ 5,000
After 1st year of employment* $30,000

* All Participants must satisfy the required waiting period for coverage. Coverage for these benefits begin when you are enrolled in this Plan.

Group Disability Insurance **

<u>New York State Statutory Disability Benefit</u>

Weekly Payment .... 50% of weekly earnings up to $170.00

Benefits begin for non-work related covered injury or illness on the 8th consecutive day of disability.

New York State Disability Benefits are payable for up to a maximum of 26 weeks. If a Participant is eligible for both Disability and Paid Family Leave (PFL) during the same period of 52 consecutive calendar weeks, the Participant shall not receive more than 26 total weeks of combined Disability and PFL benefits during the 52 consecutive week period.

New York State Paid Family Leave Benefit Schedule

Effective Date	**Benefit Amount** **% of Average Weekly Wage (“AWW”)**	**Maximum Benefit Amount** **% of Statewide Average Weekly Wage (“SAWW’)**	**Duration of Benefits**
January 1, 2018	50% of AWW	50% of SAWW ($1,305.92) or $ 652.96	Up to 8 weeks
January 1, 2019	55% of AWW	55% of SAWW ($1,357.11) or $ 746.41	Up to 10 weeks
January 1, 2020	60% of AWW	60% of SAWW	Up to 10 weeks
January 1, 2021 and thereafter	67% of AWW	67% of SAWW	Up to 12 weeks

** In the case of employees working for contributing employers who are subject to the New York Disability Benefits Law and for whom the necessary steps have been taken with the Workers’ Compensation Board, the benefits provided herein and which are described in this booklet qualify as New York Disability Benefits.

Please note, not all contributing employers provide New York State Disability Insurance benefits through the Fund. Please contact the Fund Office to ascertain if your New York State Disability Benefits are provided by your employer or the Fund.

BENEFIT DESCRIPTIONS PARTICIPANT ONLY BENEFITS

YOUR GROUP TERM LIFE INSURANCE

Effective September 1, 2018, your Group Term Life Insurance is underwritten by Anthem Life and Disability Insurance Company (hereinafter “Anthem”). The Group Case Number is AL00006573. The full description of benefits is contained in the Certificate of Insurance (“Certificate”). A copy of the Certificate of Insurance is at the Fund Office. If you would like a copy of the Certificate, contact the Fund Office. This description is solely intended to be an outline of important facts and rules contained in the Certificate of Insurance.

The Benefit

The benefit depends on how long you have been employed. Benefits are available while you are covered under the Local 1500 Welfare Fund as an active Participant. The benefits are listed in the Schedule of Benefits.

Beneficiary

Beneficiary is defined as the person you have chosen to receive the life insurance upon your death. You may name any beneficiary you like. You must file the name of the beneficiary or beneficiaries with the Fund Office. You may change your beneficiary whenever you wish, without the consent of the present Beneficiary and subject to applicable law. To change your beneficiary, you must file a change of beneficiary form with the Fund. The change will take effect as of the date the form is signed. A beneficiary cannot be changed by a Power of Attorney.

If there is a Beneficiary listed, your life insurance benefit is payable to that Beneficiary. If there is more than one Beneficiary listed, but you do not specify the share(s) to be received, all beneficiaries will share your life insurance and accidental death benefit, if applicable, equally. If the Beneficiary dies before you, that Beneficiary’s interest will end and the insurance will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise.

Any amount of insurance for which there is no Beneficiary at your death will be payable in equal shares to the first of the following categories of surviving beneficiaries: (a) your legal spouse; (b) your natural and legally adopted children; (c) parents; (d) siblings; (e) estate.

If you and your beneficiary die from the same accident and the order of deaths cannot be determined, your benefit will be paid as if you survived the beneficiary.

Burial Expense: If Anthem receives documentation that an individual incurs expenses for your burial, that person may receive part of your Group Term Life Insurance. Anthem, at its option, may pay that person up to $500.00. If more than

one person has incurred an expense for your burial, Anthem, at its option, may apply any portion of the burial expenses to the individuals. If an amount is so paid, Anthem will deduct that amount from your insurance benefit and that amount will not be paid to any beneficiary.

Insurance During Total Disability (Waiver of Premium)

If you become totally disabled* before you reach age 60, the policy contains a provision under which your Group Term Life Insurance may be extended, at no cost to you, as long as you remain totally disabled.

> *You are considered totally disabled if you are unable to perform the Material and Substantial Duties of any occupation for which you are or may become reasonable qualified by education, training or experience. You will not be considered to be totally disabled on any day that you are actively at work.

You must request extended coverage from Anthem and Anthem must receive initial proof of total disability no later than 12 months after the date your total disability began. Your request must establish that (1) you are totally disabled and that such disability began before you were 60; (2) you are still totally disabled; and (3) your total disability has continued for at least 6 months.

You must give written proof of continued total disability when requesting the waiver of premium coverage and as reasonably required by Anthem. Anthem reserves the right to have you examined by a physician of its choosing, at its expense, whenever reasonably necessary, but not more than once a year after two (2) years of total disability.

If you die while your life insurance benefit is extended due to total disability, your life insurance is payable when Anthem receives written proof that (1) your disability continued until your death; and (2) all of the above conditions have been met.

If you die within one year after your Total Disability started but before you give Anthem proof of Total Disability, written notice of your death must be given to Anthem within one year after your death and that your Total Disability continued until your death.

Your coverage under the Waiver of Premium provision will terminate the earliest of the following:

(1) You are no longer totally disabled;

(2) Three (3) months after the date Anthem requests further proof of total disability and it is not received within this period;

(3) The date you refuse to be examined by a physician after requested; and/or

(4) The date you begin to receive retirement benefits as a result of past employment with a contributing employer of the Local 1500 Welfare Fund, or with any federal, state, municipal or association retirement plan.

If your extension of benefit protection ends after you have given the first proof of continued Total Disability, you have the same rights and benefits to apply for an Individual Policy under the conversion policy listed below. However, this will not apply if you become covered again as an active Participant within 31 days after this extension of benefits ends.

To receive an extension of benefit, you must apply to Anthem. You are strongly urged to contact the Fund Office for further information if you become disabled and unable to work.

Insurance after Cessation of Total Disability

If your insurance is continued in force under this provision and is then terminated because you cease to be totally disabled or fail to submit any Proof of Total Disability that is required by Anthem, one of the following events will occur:

- If the Policy is in force and you are insured under the Policy and you are Actively at Work, you will immediately become insured under the other terms of the Policy; *or*
- If the Policy is in force but either you are not insured under the Policy or you are not Actively at Work, you will be entitled to the same conversion rights you would have been entitled to if your insurance had terminated due to the termination of your employment; *or*
- If the Policy is not in force, you will be entitled to the same conversion rights that you would have been entitled to if your insurance had terminated due to the termination of the Policy.

The period that a conversion right will apply to as described in clauses 2 and 3 will be the 31 days following the date the insurance under this provision is terminated, or any extended notice period, whichever is later.

Conversion Policy
(Change To An Individual Life Insurance Policy)

You will have the right to have Anthem issue to you an individual life insurance policy without submitting Proof of Insurability, if all or part of your insurance under the Group Policy terminates for any of the following reasons:

(1) Your employment terminates while the Group Policy is in force.

(2) Your membership in a Class terminates while the Group Policy is in force

(3) The Group Policy terminates.

(4) The Group Policy is amended to cancel the insurance on the Class of persons under which you were insured.

The policy will only be issued to you if you make a written application to Anthem and the first premium due for the policy is received at the Anthem Administrative Office within 31 days of such termination or benefit reduction, or extended notice

period, if later. This is the conversion period. Then the policy will take effect on the date of termination or reduction of coverage.

The premium for the individual policy will be determined by the policy type, the risk classification to which you belong under the group policy, Anthem's published rates in effect and your age (nearest birthday) at the time of conversion.

Individual Policies Available

The policy may be on any plan, other than term insurance which Anthem is then issuing. You may continue coverage as a term insurance policy for a period of up to one year. If your insurance terminates due to your total and permanent disability, you may elect any one of the life insurance policy forms, including term insurance, customarily issued by Anthem, subject to the conditions.

In addition to any policies available from Anthem, Anthem may also make arrangements to make policies available from another insurer.

The conversion policy will be effective on the day following the date your coverage under the group policy terminated.

Limits on the Amount of Individual Life Insurance That May be Obtained

The amount of insurance you may select under the Conversion policy may not exceed the amount of insurance that has been terminated under the Group Policy, less any amount of group coverage remaining in force under the Policy.

If the Group Policy is terminated by Anthem or the U.F.C.W. Local 1500 Welfare Fund, or if you lose coverage, in whole or in part, due to Total Disability, the amount of insurance you may select under the Conversion Policy may not exceed the amount of insurance that has been terminated under the Group Policy, less any amount of insurance for which you may become eligible under any group life insurance policy issued or reinstated within 45 days of termination of group life coverage.

Notice of Conversion Right

The U.F.C.W. Local 1500 Welfare Fund or its authorized representative is required to give you written notice of your right to convert the group policy into an individual policy without submitting Proof of Insurability. You will be given notice of the existence of the right within 15 days before or following the event which entitles you to conversion, and you will have 31 days from the event to apply for conversion your coverage. However, if such notice is given more than 15 days but less than 90 days after the happening of such event, the time allowed for the exercise of your conversion privilege will be extended by 45 days after the giving of such notice. If such notice is not given within 90 days after the happening of the event, the time allowed for the exercise of the conversion privilege will expire at the end of such 90 days. Written notice presented to you or mailed by the U.F.C.W. Local 1500 Welfare Fund, or its authorized representative, to your last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the 31 day conversion period, or at the end of the extended notice period, if later, unless properly converted within said time

Death During the Conversion Period

If you should die during the 31 day conversion period and prior to becoming insured under a policy again, an amount of insurance equal to the maximum amount for which you were entitled to convert will be paid as a death benefit.

If you terminate coverage under the Plan, you are urged to contact the Fund Office for further information on your right to convert the group life insurance policy to an individual policy.

Accelerated Death Benefit for Basic Life

The Accelerated Death Benefit provides that a portion of the Basic Life benefit otherwise payable under the policy as a result of death may be paid in advance under certain circumstances. Payment is made if you are diagnosed as having a Terminal Condition, subject to the terms of the policy and this provision.

Terminal Condition is defined as a medical condition that a Physician expects to result in your life expectancy being 12 months or less from the date of the application.

To receive the Accelerated Death Benefit, the following conditions will apply:

(1) You or your legal representative must request, in writing, to have this benefit paid while the coverage is in effect.

(2) You must provide Anthem with written permission from an assignee for your life insurance benefit, if applicable.

(3) Premium payments must continue and will be based on the reduced amount of insurance.

(4) Anthem must receive proof acceptable to it that you have been diagnosed as having a Terminal Condition.

(5) You must be living at the time this accelerated benefit is to be paid.

Accelerated Benefits are payable <u>only</u> <u>once</u> with respect to any Participant.

Any amount received under this provision will reduce the amount of life insurance coverage otherwise payable under the policy. Any benefit paid under this provision will also reduce the amount of coverage you may convert to an individual policy.

Payment under this provision does not guarantee that your full life insurance benefit will eventually be paid. Insurance must still be in force at the time of your death for the remainder of the life insurance benefit to be paid. Payment under this provision releases Anthem of all liability under the policy to the extent of the payment.

Amount of Accelerate Death Benefit

The Accelerated Death Benefit is an amount equal to 50% of the Basic Life Insurance to which you are entitled on the date you apply, in writing, for this benefit. A lesser amount may be elected. However, the minimum Accelerated Death Benefit Anthem will consider is 25% of the coverage.

Payment under this provision will be made in one lump sum. If you receive an Accelerated Death Benefit and you then recover from the qualifying condition, you will not be required to refund the benefit paid.

No Accelerated Death Benefit is payable if the Terminal Condition is directly or indirectly due to or associated with a self-inflicted injury or suicidal attempt.

If the Accelerated Death Benefit is forced by a creditor or governmental agency, Anthem will honor the request only to the extent required by law.

Anthem reserves the right to have you examined by one or more physicians of its choice, at its expense. Final determination of your eligibility for this benefit will be made by Anthem.

Claim Filing Procedures

For all Life Insurance claims, please see the Anthem Life claim filing procedures appearing later in the Claim Filing Section of this book.

YOUR BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Your Group Accidental Death and Dismemberment Insurance is currently underwritten by Anthem Life and Disability Insurance Company. The Group Case Number is AL00006573. The full description of benefits is contained in the Certificate of Insurance. A copy of the Certificate is at the Fund Office. If you would like a copy of the Certificate, contact the Fund Office.

This policy pays a benefit for any of the following losses resulting from an accident through accidental means while you are insured. To be considered for Accidental Death and Dismemberment benefits, the Loss must occur within 365 days of the accident, unless otherwise specified.

Schedule of Losses

Loss of Life..The Principal Sum (Paid to your beneficiary)

For Loss of:	The Benefits Are:
Both hands	The Principal Sum
Both feet	The Principal Sum
Sight of both eyes	The Principal Sum
One hand and one foot	The Principal Sum
One hand and sight of one eye	The Principal Sum
One foot and sight of one eye	The Principal Sum
One arm and one leg (severance above elbow and below knee)	The Principal Sum
Speech and hearing in both ears	The Principal Sum
Quadriplegia	The Principal Sum
Paraplegia	The Principal Sum
Hemiplegia	The Principal Sum

For Loss of:	The Benefits Are:
One hand	One-half of the Principal Sum
One foot	One-half of the Principal Sum
Sight of one eye	One-half of the Principal Sum
Speech	One-half of the Principal Sum
Hearing in both ears	One-half of the Principal Sum

For Loss of:	The Benefits Are:
Thumb and Index Finger of the same hand	One-quarter of the Principal Sum
Both Thumbs of both hands	One-quarter of the Principal Sum
All four fingers of one hand	One-quarter of the Principal Sum

Hearing in one ear..One-quarter of the Principal Sum
Uniplegia..One-quarter of the Principal Sum

For Loss of: The Benefits Are:
All four toes of one foot ....One-eighth of the Principal Sum

For the Loss due to a Coma, a maximum of 96% of the Principal Sum, determined as the lesser of 1% of the difference between the Principal Sum and the amount of any benefits paid for any Loss arising out of the same Accident.

Principal Sum is the benefit amount which applies to you at the time of the accident, as indicated in the Schedule of Benefits appearing earlier in this book.

Any amount payable for Accidental Death and Dismemberment Benefits will be paid to you, except in the case of your loss of life, in which case, payment will be made to your beneficiary, as determined in accordance with the Beneficiary Provision under the Policy.

The benefit will be payable when Anthem receives due Proof of a Loss. Your Principal Sum for the Accidental Death and Dismemberment insurance is shown in the Schedule of Benefits. The benefit to be paid is the amount from the Schedule of Losses noted above, subject to any conditions or reductions of the Policy. If, as the result of any one Accident, you suffer more than one of the losses shown in the Schedule of Losses with respect to any one limb, payment will be made only for the loss for which the largest amount is payable. The total maximum amount payable for all losses will not exceed your Principal Sum, unless otherwise specified by under any applicable Additional Benefit Provision.

Proof of Financial Loss

For any benefit which is based upon determination of a person's financial loss, Anthem shall have the right to require written proof of financial loss. This includes, but is not limited to:

- Statements of income;
- Tax returns, tax statements and accountants' statements; *and*
- Any other proof Anthem may reasonably require.

Anthem may perform financial audit, at its expense, as often as it deems reasonably necessary.

Definitions

Loss means a benefit from the above Schedule of Losses and, with regard to:

- An arm, leg, hand or foot, the total and irrecoverable loss of its use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such time.
- A thumb and index finger or all four fingers of one hand, the total and irrecoverable loss of its use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such time.
- Toes, the complete severance at or above the metatarsophalangeal joints.
- An eye, the total and irrecoverable loss of sight.
- Speech, the complete and irrecoverable loss of speech.
- Hearing the complete and irrecoverable loss of hearing.
- Quadriplegia, the total paralysis of both upper and lower limbs provided the loss is continuous for 12 consecutive months form the date of the loss.
- Paraplegia, the total paralysis of both lower limbs provided the loss is continuous for 12 consecutive months from the date of the loss.
- Hemiplegic, the total paralysis of upper and lower limbs on one side of the body provided the loss is continuous for 12 consecutive months from the date of the loss.
- Uniplegia, the total paralysis of one limb provided the loss is continuous for 12 consecutive months from the date of loss.
- Coma, a profound state of unconsciousness from which you cannot be aroused to consciousness, even by powerful stimulation as determined by a Physician.

Motorized Vehicle for the purpose of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles; tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. "Motorized Vehicle" does not include a medically necessary motorized wheelchair.

No Right to Convert

All Accidental Death and Dismemberment benefits terminate the day before you retire and/or when you terminate covered employment. If your Accidental Death and Dismemberment Insurance ceases or is reduced, you cannot "convert" this group insurance to an individual policy.

Additional Benefits Under the Accidental Death & Dismemberment Insurance

Additional Provision for Surgical Reattachment

If an accidental injury results in a loss that would otherwise be payable under the terms of the Policy, Anthem will reimburse an amount equal to 50% of the amount otherwise payable from the Schedule of Losses if a dismembered part is surgically reattached. The balance of the amount that would otherwise have been payable will be paid if after 365 days the reattachment has failed to the extent that loss of use then exists.

Satisfactory Proof of the accidental injury and surgical reattachment will be required at the time of claim.

Additional Benefit for Child Education

If a benefit due to your Accidental Loss of Life becomes payable under the policy, Anthem will reimburse the reasonable and necessary expenses actually incurred for each Dependent Child who is enrolled (or who enrolls within 365 days of Loss) as a full-time student and is under the age of 26 on the date of your death:

The Child must be:

- In an Accredited Institution for higher learning above the secondary school level; or
- At the secondary school level but who will enroll as full-time student(s) in an Accredited Institution for higher learning within 365 days after the date of your death.

Accredited Institution for higher learning means any university, college or trade school which is accredited by a regional accrediting agency that is recognized by the United States Department of Education.

The maximum Additional Benefit for Child Education will be the lowest of the following amounts:

- 5% of Your Principal Sum per year for each dependent child;
- $5,000 per year for each dependent child;
- $40,000 for all dependent children and all years;
- The amount of expense actually incurred.

In addition, the Additional Benefit for Child Education will not exceed a maximum of 4 years, which must run consecutively from your date of death, with respect to any one dependent child.

The Additional Benefit for Child Education will be reimbursed annually upon receipt of satisfactory proof that the dependent child is attending an Accredited

Institution for higher learning as a full-time student, but reimbursement will not be made for expenses incurred prior to your death, or for room, board or other ordinary living, traveling or clothing expenses.

In the event the dependent child satisfies the requirements indicated above and has reached the age of legal majority, such child will be deemed the beneficiary with respect to benefits payable under this Additional Benefit. If the dependent child satisfies the requirements indicated above and has not yet reached the age of legal majority, the benefit will be payable annually to the legal guardian of the estate of the dependent child, until such child reaches the age of legal majority.

If a benefit due to your Accidental Loss of Life becomes payable under the Policy, and you do not have a child eligible for the Additional Benefit for Child Education, a lump sum of $500 will be paid in accordance with the Beneficiary Provisions of the Policy.

Additional Benefit for Repatriation

If you sustain Accidental Loss of Life more than 75 miles from your normal place of residence and indemnity for such Loss becomes payable under the terms of the Policy, Anthem will reimburse expenses incurred for the transportation of your body, subject to all of the terms and limitations of the Policy and all of the following conditions:

- Reimbursement for all expenses under this Additional Benefit will not exceed $5,000;*and*
- Eligible expenses will include transportation of the body, and charges directly related to the preparation of the body for such transportation; *and*
- Transportation of the body will be to the first resting place (including, but not limited to, a funeral home or the place of interment) in proximity to the normal place of residence of the deceased; *and*
- Satisfactory Proof of the actual expenses is submitted at the time of claim.

The Additional Benefit will be paid to your beneficiary, as determined in accordance with the Beneficiary Provision(s) under the Policy.

Additional Benefit for Seat Belt and Air Bag

If a benefit due to your Accidental Loss of Life becomes payable under the terms of the Policy, Anthem will pay an Additional Benefit, called the Seat Belt and Air Bag Benefit, if you were wearing a Seat Belt at the time of the accident, or if you were wearing a Seat Belt and the Automobile was equipped with Air Bag(s) at the time of the Accident, subject to all of the terms and limitations of the Policy and all of the following conditions:

- The Seat Belt Benefit equals the lesser of (i) $15,000 or (ii) 10% of the amount of the Accidental Death and Dismemberment Insurance Benefit paid because of your Accidental death in accordance with the Schedule of Losses.
- The Air Bag Benefit equals the lesser of (i) $10,000 or (ii) 10% of the amount of the Accidental Death and Dismemberment Insurance Benefit paid because of your Accidental death in accordance with the Schedule of Losses.
- Satisfactory Proof that your death resulted from an Automobile Accident independent of all other causes, and that you were wearing a seat belt at the time of the Accident must be received at the time of claim. Proof that the Automobile was equipped with Air Bags may also be required.
- No payment will be made for an Air Bag Benefit if at the time of the accident you were not in a seat for which the automobile provided an Air Bag, and wearing a Seat Belt.
- A copy of the police accident report must be submitted with the claim. The report must certify the position of the Seat Belt.
- No payment will be made for the Seat Belt or Air Bag benefit for any Insured who is driving or riding as a passenger if:
    - o The blood alcohol of the driver or operator of the Automobile is in excess of the legal limit in the jurisdiction in which the Accident occurred; *or*
    - o The use of any intoxicant or drug by the driver or operator of the Automobile is determined to be a contributing cause of the Accident, whether or not the Intoxicant or drug was prescribed by a Physician.
    - o The Insured was riding, driving or testing a motorized vehicle used in a race or speed contest.

The Additional Benefit for Seat Belt and Air Bag will be payable to your beneficiary, as determined in accordance with the Beneficiary Provision(s) under the Policy.

For the purposes of this Additional Benefit:

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Automobile means a motor vehicle licensed for use on public highways which is a self-propelled passenger vehicle that has four wheels and an internal combustion engine. It may include electric passenger vehicles and certain hybrids. It excludes all other motorized vehicles.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile that inflates upon collision to protect an individual from Injury and death.

Additional Benefit for Common Carrier

If you sustain an accidental injury which results in a loss payable under the terms of the Policy, an Additional Benefit of 25% of the Principal Sum will be paid, if your injury or loss of life is sustained while you are boarding, riding, or exiting as a fare-paying passenger in a Common Carrier.

Common Carrier means a government licensed and regulated entity that is in the business of transporting fare paying passengers. The term Common Carrier does not include:

- chartered or other privately arranged transportation; *or*
- taxis; *or*
- limousines.

Exclusions for Accidental Death & Dismemberment

The following exclusions apply to any and all Accidental Death & Dismemberment Benefits, including any Additional Benefits or Additional Provisions, unless otherwise specifically referenced.

No payment will be made for any Accidental Death and Dismemberment Benefit or under any Additional Benefit or Additional Provision for any death or loss that results directly or indirectly from, or was in any manner or degree associated with or caused by any one or more of the following:

- Bodily infirmity or mental or emotional disorder or illness or disease of any kind, or any medical or surgical treatment, diagnostic or preventative care (unless the treatment or care is provided in connection with a loss).
- Infections, unless caused by an injury.
- Poisoning in any form, including but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol or any combination thereof.
- Loss or injury which occurs while the Insured is in the course of operating any Motor Vehicle if the Insured's blood alcohol concentration is in excess of the legal limit in the jurisdiction in which the Accident occurred.
- Suicide or attempted suicide or intentionally self-inflicted injury.
- Committing or attempting to commit a felony, or engaging in an illegal occupation.
- War or act of war (whether declared or undeclared); service in the armed forces or auxiliary units thereto.
- Participation in any riot or insurrection.
- Being under the influence of any narcotic or intoxicant, unless administered by or taken according to the advice of a Physician.
- Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- Serving in the military of any country or subdivision of any country.

Claim Filing Procedures

For all Accidental Death and Dismemberment claims, please see the Anthem claim filing procedures appearing in the Claim Filing Section of the book.

YOUR DISABILITY INSURANCE

Underwritten by Unicare Life and Health Insurance Company

PLEASE NOTE: Some contributing employers provide New York State Disability Law Benefits through their own insurance carriers. You should contact the Fund Office to determine where disability claims are to be filed.

New York State Statutory Disability Coverage

You will receive weekly payments if you are unable to work because of a covered non-occupational accident or sickness and are under the regular care of a doctor. The amount of the payment and the day it begins are shown in the Schedule of Benefits appearing earlier in the book.

Payments will continue as long as you are disabled, up to the maximum appearing in the Schedule of Benefits.

Successive disabilities separated by less than two weeks of full-time work will be considered one disability, unless the subsequent disability is due to a different cause and does not begin before you return to full-time work.

The maximum number of weeks for which disability benefits are payable will be 26 weeks during any one period of disability or during a 52-week period and during any one disability. If a Participant is eligible for both Disability and Paid Family Leave (PFL) during the same period of 52 consecutive calendar weeks, the Participant shall not receive more than 26 total weeks of combined Disability and PFL benefits during the 52 consecutive week period.

EXCLUSIONS

Benefits will not begin until the day shown in the Schedule of Benefits.

This benefit does not cover:

1. Disability due to an accident related to any employment.
2. Sickness and/or injury covered under Workers' Compensation or similar law
3. If you are receiving unemployment benefits.
4. Self-inflicted injury.
5. Disability resulting from perpetration of an illegal act.
6. For any period for which you performed work for remuneration or profit, when the disability benefit plus any remuneration from your employer exceeds your regular weekly wage prior to disability.
7. You are not under the care of a licensed physician, podiatrist, chiropractor, nurse-midwife, dentist or Case Nurse Manager acting within the scope of his/her practice.
8. Disability due to any act of war (declared or undeclared).
9. High school students while attending school.

New York State Paid Family Leave (NYS PFL)

Full-Time Participants covered for disability under the Fund are eligible for NYS PFL coverage after 26 weeks of consecutive employment.

An employee may take NYS PFL for the following reasons:

1. Bonding with a Child during the first 12 months following birth, adoption or fostering of a child. Spouses with different employers are both eligible to take PFL at the same time. However, if both spouses have the same employer, the employer can deny PFL to one of the spouses if they have asked for the same period off.

2. The Serious Illness of a Family Member (Family Care). These include spouses, domestic partners, children, parents, parents-in-law, grandparents and grandchildren. A serious health condition is defined as an illness, impairment or physical or mental condition that involves inpatient care in a hospital, hospice or residential heath care facility or continuing treatment or supervision by a health care provider.

3. Active Military Duty Deployment when a spouse, child, domestic partner or parent of the employee is on active military duty abroad or has been notified of an impending call or order of active military duty abroad. NYSPFL may be taken by employees who are also eligible for time off under the military provision in the federal FMLA.

Under the statute, the cost for this coverage is to be paid by the employees through a payroll deduction. The cost is based upon the employee's weekly wage. For calendar year 2018, the amount of the employee contribution is 0.126% of his/her average weekly wage, up to an annual maximum of $85.56. Effective January 1, 2019, the premium to be paid is 0.153% of an employees' average weekly wage, up to an annual maximum of $107.97.

The benefit amount and the duration of allowable leave time is noted in the Schedule of Benefits appearing earlier in this book.

CLAIM FILING PROCEDURES

Life, Accidental Death & Dismemberment (AD&D) and Disability Claims

Life and AD&D Underwritten by Anthem Life & Disability Insurance Company
Disability Underwritten by Unicare Life and Health Insurance Company

How to File a Claim for Life or Accidental Death and Dismemberment

In case of the death of a participant or accidental injury to a participant, contact the Welfare Fund Office immediately by telephone at 516-214-1300 or 1-800-522-0456 for a claim form. The proper claim forms will be furnished to your beneficiary in case of your death; or to you or your authorized representative in case of injury.

The claim form will have instructions on how to complete the form. The claim form must be fully completed. Incomplete claim forms may be cause for delay in processing.

If the claim for benefits is for your death, Anthem may require an autopsy, unless it is prohibited by law. The cost for any such examination is paid by Anthem.

Proof of Loss

Anthem must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss and must identify you as the claimant, your address and the Fund's group policy number. For a claim for loss of life, a certified copy of the death certificate <u>must</u> be provided to the carrier. It must be furnished within 90 days after the date of the loss, except that:

1. If any coverage provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end.
2. If payment is to be made for charges incurred during a calendar year, the proof for that calendar year must be furnished within 90 days after its end.

A claim will not be considered valid unless the proof of loss is furnished within these time limits. However, it may not be reasonably possible to do so. In those cases, the claim will still be considered valid if the proof is furnished as soon as reasonable practicable. Please note, unless the delay in supplying proof is caused by your legal incapacity, the required proof must be furnished no later than 1 year from the specified time.

For a claim for Waiver of Premium, notice must also be given during your lifetime and during the period of total disability.

How to File a Disability and NYS PFL Claims

In the event of a disability claim, contact the Welfare Fund Office by telephone at 516-214-1300 or 1-800-522-0456 or you may write to the Fund Office at 425 Merrick Ave, Westbury, NY 11590. The necessary claim forms will be forwarded

to you for completion. You may also contact Unicare at 1-888-868-7046, Monday – Friday 8 AM – 8 PM Eastern Time to file a claim.

For Disability benefits, you must file a claim for benefits (DB-450) within 30 days from the first date of your disability. If you are filing a claim for benefits after you have been out of work for over 30 days, you must use form DB-300. You complete the "Claimant Section" and your health care provider must complete the "Health Care Provider's Statement" on the claim form showing the period of your disability.

If you are filing a NYS PFL claim, you must complete the "Claimant Section" and your employer must complete the "Employer Section". You should notify your employer at least 30 days before your leave is to start, if practicable. Otherwise, you should notify your employer as soon as possible.

If you go out on disability for any reason, you should contact the Fund Office immediately for information on your disability coverage.

Please note, some contributing employers provide New York State Disability Law benefits through their own insurance carriers. You are urged contact the Fund Office to determine where disability claims are to be filed.

Hospital, Medical, Dental, Orthodontic and Vision Claims

All claims, except Anthem BlueCross BlueShield claims, must be submitted within 2 years of date of service. Any claim not received within this time period will be denied as an untimely filing of benefits.

Anthem claims must be submitted within 18 months.

How to File In-Network Hospital and Medical Claims & Out-of-Network Medical Claims

All In-Network providers are required to submit claims to the Anthem/Empire BlueCross Blue Shield in the State where services are rendered. Providers submit the claims according to the agreements by and between Anthem/Empire BlueCross BlueShield and the provider.

For claims incurred in New York, send completed forms to:

Hospital Claims:

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

Medical Claims:

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

Out-of-Network Medical Claims:

The completed claim form should be submitted to:

Associated Administrators, LLC
U.F.C.W. Local 1500 Welfare Fund
P.O. Box 1095
Sparks, MD 21152-1095

Tips for Filing Claims

- All claim forms must be fully completed.
- For Out-of-Network claims, attach original bills or receipts.
- If the Fund is the secondary payer under its Coordination of Benefit rules (explained later in this book), submit the original or a copy of the primary payer's Explanation of Benefits (EOB) and your itemized bill with the claim.
- Keep a copy of your claim form and all attachments for your records.

How to File Dental and Orthodontic Claims

The universal American Dental Association claim form in lieu of the Fund's dental claim form maybe filed on your behalf. If using the Fund's dental claim form, you complete the participant's portion of the claim form and the dentist completes the rest. It is important that your identification number be included on the form.

Payment will be made to you unless you have assigned the payment to the dentist.

The completed claim form should be submitted to:

Associated Administrators, LLC
U.F.C.W. Local 1500 Welfare Fund
P.O. Box 1095
Sparks, MD 21152-1095

No claims will be paid if submitted more than two (2) years after completion of the service for which claim is made.

How to File a Vision Care Claim

If you choose to go to a participating provider, the General Vision Services, Inc., Vision Screening, Inc., Comprehensive Professional Systems, Inc. and New County Optical networks will submit the claim on your behalf.

If you choose to use an Out-of-Network provider, you will need to submit the claim for benefits. You should contact the Welfare Fund Office for a Vision Care Claim Form before visiting the licensed optometrist, optician or ophthalmologist. Complete the "Claimant's Statement" portion of the claim form. Upon completion

of the work, the optometrist or ophthalmologist must complete the "Doctor Statement" portion of the claim form. Submit the claim form to the following address:

Associated Administrators, LLC
U.F.C.W. Local 1500 Welfare Fund
P.O. Box 1095
Sparks, MD 21152-1095

No claims will be paid if submitted more than two (2) years after completion of the service for which claim is made.

NOTICE

You can check the status of a claim at any time of day or night just by visiting www.associated-admin.com and selecting the U.F.C.W. Local 1500 Welfare Fund under the "your Benefits" tab. Click on the MemberXG Benefit System link at the top of the page and create an account to review your claims.

CLAIM APPEAL PROCEDURES

Types of Health Care Claims (i.e., Hospital, Medical, Prescription Drugs, Dental, Orthodontic and Vision Benefits)

There are four (4) basic types of health care claims:

Pre-Service. A pre-service claim is a claim for benefits where prior authorization is required. Failure to obtain prior authorization of a pre-service claim may result in a denial and/or reduction of benefits for such service unless:

- It was not possible for you to obtain prior authorization; or
- The prior authorization process would jeopardize your life or health.

Urgent Care. An urgent care claim is a type of a pre-service care claim. An urgent care claim is a claim for medical care or treatment for a medical condition that:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Post-Service. A post-service claim is a claim for Fund health care benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services which form the basis for your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Concurrent Care. A concurrent care claim is a claim that is reconsidered after it was initially approved (such as recertification of the number of days of an inpatient hospital stay) and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

Timing of Determination of Health Care Claims

The deadline for making a determination about your health care claim differs depending on the types of claim you have, as shown in the following paragraphs:

Urgent Care Claims: An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally as soon as possible, but no later than 72 hours, and then will be confirmed in writing within three days after the oral notice. If additional information is needed from you to process your claim, you will be notified as soon

as possible, but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. You will then be notified of the Fund's benefit determination on the urgent care claim as soon as possible, but no later than 24 hours after the earlier of the receipt of the information or the end of the period of time allowed to you in which to provide the information.

Pre-Service Claims: An initial benefit determination will be made within 15 calendar days from receipt of your pre-service claim. If additional time is necessary to make a benefit determination on your pre-service claim due to matters beyond the control of the Fund, the Fund may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 15 day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 15 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Fund's benefit determination on the pre-service claim as soon as possible, but no later than 15 days after the earlier of the receipt of the information or the end of the 45 day time period allowed to you in which to provide the information.

Post-Service Claims: Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days from the Fund's receipt of the claim. This period may be extended one time by the Fund for up to 15 additional days, if the extension is necessary due to matters beyond the control of the Fund. 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 Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Concurrent Care Claims: While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Fund will act on your request in the same manner as urgent care claims.

If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision about your claim.

If A Health Care Claim Is Denied (Hospital, Medical, Prescription Drugs, Dental, Orthodontic and Vision Claims)

An adverse benefit determination (*i.e.*, a "denial") of a health care claim is defined as:

1. A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on a determination of an individual's eligibility to participate in the Fund's coverage or that a benefit is not a covered benefit;

2. A reduction in or denial of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and/or

3. Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Notice of Health Care Claim Denials

If your claim is denied, in whole or part, you will be provided with written notice of a denial of the claim. This notice will:

1. Include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);

2. State that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;

3. State the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Fund standards used in denying the claim;

4. Reference the specific provision(s) on which the determination is based;

5. If relevant, describe any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

6. Provide a description of the Fund's internal appeal procedures (including voluntary appeals) and external review processes, along with the applicable time limits and information on how to initiate an appeal;

7. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;

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

9. Contain a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal; and

10. Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes. The Fund will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Fund can deny your claim on appeal 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 denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Internal Appeals of Health Care Claims

If your claim for health care benefits is denied, in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for appeal must be made in writing to the Board of Trustees within 180 days of the date of the denial. Please send your appeals of denied health care benefits to the Board of Trustees at the following address:

The Board of Trustees
U.F.C.W. Local 1500 Welfare Fund
c/o Associated Administrators, LLC
PO Box 1095
Sparks, MD 21152
Attn: Appeals Department

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service. You have the right to submit written comments, documents, records and other information relating to your claim. The review will take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial benefit determination.

A different person/entity will review your claim other than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including additional documents and comments that you may submit.

If your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.

Timing of Appeal Decision of Health Care Claims

The Fund's decision on your appeal will be made within the following time frames:

Urgent Care Claims: A decision will be made as soon as possible, but not later than 72 hours after receipt of your appeal.

Pre-Service Claims: A decision will be made within 30 calendar days from receipt of your appeal.

Post Service Claims: A decision 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, it will be considered at the second regularly scheduled meeting following receipt. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request may be necessary. You will be advised in writing in advance if this 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 5 days after the decision has been reached.

Concurrent Care Claims: A determination will be made before termination of your benefit.

Notice of Decision on Appeal of Health Care Claims

The decision on any review of your appeal will be given to you in writing. The notice of a denial of an appeal will include:

1. Information sufficient to identify the claim, including date of the service, health care provider, and claim amount;
2. A statement that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided to you. However, a request for this information will not be treated as a request for a voluntary appeal or external review;
3. A statement you may receive, upon request and free of charge, access to copies of documents relevant to your claim;
4. The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any standards used in denying the claim;
5. Reference to the specific provision(s) on which the determination is based;
6. If relevant, any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
7. A description of the Fund's internal appeal procedures and external review processes, along with the applicable time limits and information on how to initiate an appeal;
8. A statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;
9. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
10. If the determination was based on the absence of medical necessity, 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 Fund to your claim, or a statement that it is available upon request at no charge;
11. The following statement: "You and your plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."
12. Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

NOTE: The Fund will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of

the Fund) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Fund can issue a denial on appeal 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 denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Limitation on When a Lawsuit or External Review May Be Started

You may not seek external review or start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on your appeal, or until the appropriate time frame in which the Fund must decide your appeal, as described above, has expired and you have not received a final decision on your appeal or notice that an extension will be necessary to reach a final decision. However, 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 Fund has failed to follow such procedures.

External Reviews of Health Care Claims

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an Independent Review Organization ("IRO") as described below. In the normal course, you may **only** request external review after you have exhausted the internal review and appeals process described above.

Furthermore, external reviews are **<u>only</u>** available for the following types of denials of claims:

- A denial that involves medical judgment, including those based on the Fund's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Fund.

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial you are appealing. Because

the Fund's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

    (a) Within five (5) business days of the Fund's receipt of your external review request, the Fund will complete a preliminary review of the request to determine whether:

    - You are/were covered by the Fund at the time coverage for the health care item or service is/was requested or, in the case of a retrospective review, were covered at the time the health care item or service was provided;
    - The denial does not relate to your failure to meet the Fund's requirements for eligibility;
    - You have exhausted the Fund's internal claims and appeals process; and
    - You have provided all of the information and forms required to process an external review.

    (b) Within one (1) business day of completing its preliminary review, the Fund will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

    - If your request is complete and eligible for external review, or
    - If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 866-444-EBSA (3272)], or
    - If your request is not complete, the notice will describe the information or materials needed to make it complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review by an Independent Review Organization (IRO)

    If the request is complete and eligible, the Fund will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Fund has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

    Once the claim is assigned to an IRO, the following procedure will apply:

    (a) The assigned IRO will timely notify you, in writing, of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

    (b) Within five (5) business days after the assignment to the IRO, the Fund will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must, within one (1) business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its denial of the claim which is the subject of the external review. Reconsideration by the Fund will not delay the external review. However, if upon reconsideration, the Fund reverses its original denial of the claim, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines, the applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Fund within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's notice of its decision will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding, except to the extent that

other remedies may be available to you or the under applicable State or Federal law;

- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Health Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial of an appeal that involves a medical condition for which the time to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or, you receive a denial of an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review of Expedited External Reviews

Immediately upon receipt of the request for expedited external review, the Fund will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 1(a), are met. The Fund will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 1(b).

Review by an Independent Review Organization (IRO)

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO. The Fund will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review noted above. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the Fund's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with Section 2(f) above, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Fund.

After External Review

If, upon external review, the IRO reverses the denial of your claim, upon the Fund's receipt of notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. If the final external review upholds the denial of the claim, the Fund will not provide coverage or payment for the reviewed claim. If you are dissatisfied, you may seek judicial review as permitted under ERISA Section 502(a).

Appeals for Group Term Life and Group Accidental Death & Dismemberment (AD&D) Insurance Underwritten by Anthem Life & Disability Insurance Company

Claims for Life Benefits (Other Than Waiver of Premium) and AD&D

If you or your beneficiary's claim for benefits is totally or partially denied, Anthem will provide you written notice. This notice will give the reason(s) for the denial. If you or your beneficiary/beneficiaries do not agree with the reason(s) given, you may request a reconsideration of the claim.

To do so, you or your beneficiary/beneficiaries must write to Anthem within 60 days after receipt of the notice of denial. You or your beneficiary/beneficiaries should indicate why you believe the claim was improperly denied and include any additional information, data, questions or comments you believe are appropriate. Unless Anthem receives a request for additional information, you or your beneficiary/beneficiaries will be advised of Anthem's decision within 60 days after Anthem receives the request for reconsideration. The address to mail your request for reconsideration will be on the initial denial and is contained in the Certificate of Insurance held at the Fund Office.

Claims for Waiver of Premium

A decision for a Waiver of Premium claim will be made by Anthem within 45 days of the date the claim is filed. Under special circumstances, this decision may take up to another 60 days. You will be notified, in writing, of the reason for the delay, if any. Anthem will send written notification of its determination.

If you do not understand Anthem's decision or you disagree, you may request a review of the denied claim within 180 days of receipt of written notice that your claim has been denied. You may also review the pertinent documents and submit comments in writing.

Anthem will make a decision within 45 days after your request for review is made, unless circumstances of the claim require an extension, in which event the decision will be made as soon as possible, but not longer than 90 days after the request for review is made.

You will receive Anthem's written decision, which will include the reason(s) for the decision, along with references to the Policy provisions on which it is based.

Legal Action

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after Written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time Written Proof of Loss. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained Anthem's reconsideration of that claim, as explained above

Appeals for Group Disability Claims
Underwritten by Unicare Life & Disability Insurance Company
(A subsidiary of Anthem Life & Disability Insurance Company)

If you file a claim with Unicare and Unicare denies your claim outright or is terminating your benefits once started, it must give you the claim rejection within 45 days of the filing of your claim. Unicare is required by New York Disability Law to notify you of a termination of disability benefits on DB-451 form. Unicare is required to provide you with three (3) copies of the Notice of Rejection, DB-451 form. Please note, your employer is entitled to receive one of the DB-451 forms.

The DB-451 form explains the reason for your denial and/or termination of benefits and provides instructions for your appeal to the State of New York. The DB-451 will be mailed to you by Unicare in a separate letter after the termination and/or denial of your benefits. The notice will state the reason(s) benefits are not being paid or are being terminated. If you do not agree with Unicare's decision, you have the right to request a review of the rejection by the Workers' Compensation Board within 26 weeks of the commencement of your disability. If you elect to do so, the request for review must be in writing by you or your authorized representative. In filing your request for review, you may identify the issues and present additional evidence that you wish considered, including any pertinent documents you may wish examined.

All appeals and correspondence should directed to:

Workers' Compensation Board
Disability Benefits Bureau
100 Broadway – Menands
Albany, NY 11241-0005

<u>PLEASE NOTE</u>, The Fund provides NYS Disability benefits for certain contributing employers. You are urged to contact the Fund Office to ascertain if your employer provides these benefits through the Fund.

SUBROGATION (CLAIMS INVOLVING THIRD PARTY LIABILITY)

Note:

This provision applies to all participants and their covered dependents with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms “you” and “your” refer to all participants and covered dependents.

General

Under the terms of the Plan, no benefits are payable if a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this Plan pays all benefits in such situations.

These rules have two purposes. First, the rules ensure that your medical, dental and optical expenses will be paid promptly. Often, where there are questions of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay the expenses which would have been covered if a third party were not liable before your dispute with the third party liability is resolved.

Second, the rules protect this Plan from bearing the expenses in situations where a third party is liable. Under these rules, once you receive any compensation with respect to the third party’s liability, this Plan must be reimbursed for the amount it has advanced to you.

Rights of Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to advise the Plan of that fact.

The Plan may pay such expenses, up to coverage limits, provided that you agree, in writing, to repay the Plan, in full, from any settlement, judgment, or other payment that you obtain from the liable third party or insurance carrier. The amount of the payment to the Plan may not be reduced by any expenses incurred in obtaining the recovery. The Plan is entitled to such repayment even if nothing in the judgment or settlement allocates any portion of the proceeds to medical expenses. Moreover, the Plan is entitled to repayment from any trust or fund set up for your benefit.

The Trustees will require you (or your authorized representative if you are a minor or incapacitated) and your attorney to execute this Plan’s lien forms before this Plan pays you any benefits related to such expenses.

No benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan if you retain another attorney or an additional attorney since that attorney will be required to execute the form and acknowledge the Fund's lien.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH THE FUND'S RIGHT TO REIMBURSEMENT. NOR WILL SUCH FAILURE BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION OR REIMBURSEMENT.

Assignment of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If you assign your claim and this Plan recovers from the third party, any amount in excess of the benefits paid to you plus the expenses incurred in obtaining the recovery will be paid to you.

Failure to Disclose and/or Cooperate

If you fail to tell this Plan that you may have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and to cooperate with the Plan's subsequent recovery efforts); if you fail to require any attorney you retain to sign the Plan's lien forms; if you and/or your attorneys fail to repay this Plan in full out of any payment you obtain from the third party or insurance carrier; then you will be personally liable to this Plan for the amount owed to this Plan. The Plan may offset the amount you owe from any future benefit claims, or if necessary, take all legal action available against you to recoup the amount owed.

PLAN INTERPRETATIONS AND DETERMINATIONS

Notwithstanding any other provisions of this Plan, the Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion:

- To determine whether an individual is eligible for any benefits under the Plan;
- To determine the amount of benefits, if any, an individual is entitled to from the Plan;
- To determine or find facts relevant to any claim for benefits from the Plan;
- To interpret all of the Plan's provisions;
- To interpret all of the provisions of the Summary Plan Description;
- To interpret the provision of any collective bargaining agreement or written participation agreement which refer or relates to the Plan;
- To interpret the provisions of the Trust Agreement governing the operation of the Plan;

- To interpret all of the provisions of any other document or instrument which refers or relates to the Plan;
- To interpret all of the terms used in this Plan and all of the other previously mentioned agreements, documents and instruments and;
- To amend, modify, or discontinue all or part of the Plan whenever, in their sole and absolute discretion, conditions so warrant.

All such determinations and interpretations made by the Trustees:

- Shall be final and binding upon any individual claiming benefits under the Plan and upon all employees, all employers, the Union, and any party who has executed any agreement with the Welfare Fund Trustees or the Union;
- Shall be given deference in all courts of law to the greatest extent allowed by applicable law; and
- Shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, acted in an arbitrary and/or capricious manner.

Incompetence

If the Trustees determine that a person entitled to benefits from the Plan is unable to care for his/her affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees, be made to that person's spouse, child or such person who shall have care and custody of that person.

Cooperation

Every claimant will furnish to the Trustees all such information, in writing, as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for denying and/or delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may, from time to time, adopt such formulas, methods and procedures as they consider advisable.

Mailing Address of Claimant

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment can be successfully made. Be sure to inform the Trustees immediately of any change of address.

Recovery of Payment

The Trustees have the right to recover any overpayment or payment made in error to you or to a third party on your behalf, or any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted. Such a recovery may be made by reducing other benefit payments made to you or on your behalf, by commencing a legal action or by such other methods as the Trustees, in their sole and absolute discretion, determine to be appropriate.

COORDINATION OF BENEFITS

The purpose of the benefits provided by the Fund is to help you pay your medical bills. It is not intended that benefits exceed medical expenses you incur. For this reason, this Plan contains a Coordination of Benefits ("hereinafter "COB") provision. Pursuant to the COB provision, if you or any of your eligible dependents are covered by more than one health "plan", as defined below, this Plan will coordinate with the other plan so that the total amount paid on any claim by all plans will not exceed 100% of the allowable benefit under the Plan. In other words, there is no duplication of benefits.

An "allowable" expense is any necessary, reasonable and customary expense covered, at least in part, by this Plan.

"Plan" means any plan providing benefits for services for or by reason of medical, dental and optical care or treatment, which benefits or services are provided by:

3. Group blanket or franchise insurance coverage;
4. Hospital service prepayment plan, medical service prepayment plan, and group practice plan;
5. Any coverage under a labor-management jointly trusteed plan, union welfare plans, employer organization or employee benefit plans;
6. Any coverage under governmental programs to the extent permitted by law, and any coverage required or provided by any statute;
7. Any coverage sponsored by, or provided through, a school or other educational institution;
8. Medicare, including benefits provided by the Part B of the Medicare Provisions;
9. Automobile insurance, including but not limited to no-fault or personal injury protection insurance;
10. Any personal insurance;
11. Any plan which considers itself "excess";
12. Medical payments coverage available under a homeowner's insurance policy.

A. Coordination of Health Benefits with other Plans in which Eligible Spouses may be Eligible to Participate

The U.F.C.W. Local 1500 Welfare Fund Full-Time Plan provides as follows:

1. If you are a working spouse and you receive benefits under your employer's plan and you have been determined to be eligible under the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan, your employer's health plan is primary for services rendered to you and this Plan is the secondary plan. (See Section (C) (1) below.)

2. If you are a working spouse who receives dependent coverage for your children and those children are also covered under this Plan, the U.F.C.W. Local 1500 Welfare Fund's "Birthday Rule," which dictates which parent's health plan provides primary coverage for dependent children, will dictate which plan is primary (see Section (C) (1) below.)

B. Coordination with Reimbursement Programs

In the event that any plan under which you are covered is established as a "reimbursement type" of plan ("secondary to all other plans" or an excess plan) rather than an "insurance type" of plan, the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan will operate automatically as a secondary plan to that reimbursement plan.

C. Coordination with Other Plans

1. In the event a person who is covered under the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan is also covered under another health care plan, the benefits under the two plans will be coordinated. A determination will be made as to which plan is the "first" or "primary" plan and which plan is the "second" or "secondary" plan. The method of determining which plan is "first" is based on the following rules:
   - A plan covering a person as an employee will be considered "primary" and will pay benefits first.
   - A plan covering a person as a dependent will be considered "secondary" and will pay benefits second.
   - If a dependent child is covered by both parents' plans, the plan of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be primary. The plan of the parent whose date of birth, excluding year of birth, occurs later in the calendar year, will be secondary. This is called the "birth-date rule". If a plan containing the "birth-date" rule is coordinating with a plan which contains the "gender-based" rule (that is when the Plan makes the male parent primary by virtue of gender) and as a result the plans do not agree on the order of payment/processing, the "gender based" rule will determine the order.

2. When the parents are divorced or legally separated the coverage of the parent with custody pays first. The coverage of the parent without custody pays second.

   If the parent with custody has remarried, the coverage is as follows; the plan of the parent with custody pays first, the plan of the step-parent pays second and the plan of the parent without custody pays last.

   However, if the Fund receives a Qualified Medical Child Support Order (QMCSO) and it is determined that the QMCSO meets the necessary requirements, the parent whose responsibility is stated in the QMCSO is the primary plan. A valid QMCSO supercedes any payment order listed above.

3. If a person is covered under more than one plan, the plan he or she was covered under longer pays first, except in the case of a laid off or retired employee, or dependent of such person.

If the U.F.C.W. Local 1500 Welfare Fund Full-Time Plan is the primary plan, it will pay its benefits as if there were no other such plan. If this Plan is the secondary plan, it will pay its benefits in accordance with Plan guidelines, however this Plan will adjust its benefit payment accordingly so that the total benefits paid will not exceed 100% of the allowable charge under the Plan.

D. Coordination with Medicare

1. Coverage at Age 65 and Over for Active Employees And Their Dependent Spouses

Medicare provides health insurance for persons 65 or over, whether they are retired or still working (and for most persons under 65 who have been determined to be disabled for two or more years). Thus, when you reach age 65, Medicare will become an important part of your protection against medical expense.

If you remain employed after you reach age 65 and work for an employer with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year or if the Fund has not obtained an exception for your employer, you have the following options:

a) This Plan as your primary coverage and Medicare as your secondary coverage means that you shall continue to submit all your claims to this Plan and receive the same benefits as any younger employee. Medicare would then consider a claim for any remaining expenses. If you have the Fund for your primary coverage, you and your eligible dependents are entitled to all benefits provided under the Fund, at no cost to you.

b) Medicare alone – You may choose not to participate in this Plan and have Medicare as your only coverage. You would submit claims only to Medicare. (Medicare has certain deductibles and copayments for most services as well as premiums to be paid for coverage.)

c) This Plan alone – You may choose not to enroll under Medicare and have this Plan as your only coverage.

d) Disabled Dependents Under 65 - This Plan is primary for active employees whose eligible dependents are under age 65 and who are entitled to Medicare benefits due to total disability (other than End Stage Renal Disease).

e) End Stage Renal Disease – The Plan will remain primary for End Stage Renal Disease (ESRD) to the extent required by law. Thereafter, Medicare is primary and the Plan secondary. .

2. Coverage at age 65 and over for Employees on a Self-Pay Basis pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA)

If you are a Participant or a dependent spouse who is covered under this Plan and Medicare while the Participant is still actively working, if the Participant stops employment and elects COBRA continuation coverage, Medicare is the primary payer and this Plan is the secondary payer. If you or a family member has Medicare based on a disability and also have COBRA continuation coverage, Medicare is the primary payer and this Plan is the secondary payer. This means that you or your dependent spouse must submit your claims first to Medicare for payment. This Plan would then make a determination on a claim for any expenses not paid by Medicare.

Please note, under COBRA guidelines, if you are covered under Medicare Part A, you are presumed to be covered under Medicare Part B. Therefore, if you are covered under Medicare Part A (hospitalization coverage) while you are covered under COBRA but not under Medicare Part B while you are also covered under COBRA, the Fund will not pay claims for which Medicare Part B would have been primary. A Medicare EOB (called a Remittance Notice or Advice) must be sent to the Fund along with your claim for benefits showing Medicare paid as primary in order for the Fund to pay as secondary. Medicare Part B is not automatic and you must enroll in Medicare Part B coverage.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)
CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (hereinafter COBRA) provides that you can continue health care coverage for yourself and eligible dependents under certain circumstances where coverage would otherwise end (called "qualifying events"). This section outlines your rights and obligations with respect to continuation of the health benefits provided under this Plan. Your cost for COBRA continuation coverage will be 102% of the cost of coverage for an active Participant in the same plan, (excluding the Life and AD&D Insurance, as well as the NYS Disability Insurance, where applicable). In the case of a disability extension of your COBRA coverage, your cost is 150% of the cost of coverage. COBRA continuation coverage does not include the Life, Accidental Death and Dismemberment Insurance and NYS Disability Insurance, where applicable. If your coverage terminates, you have the right to convert the Group Term Life Insurance to an individual policy. You must request conversion within 31 days of your termination. You are urged to contact the Fund Office for information on your conversion rights upon termination for your Group Term Life Insurance. There is no right to convert the Group Accidental Death and Dismemberment Insurance.

You have a right to choose continuation coverage, for up to a maximum of 18 months, if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you become covered by Medicare within 18 months of a termination or reduction, you may be eligible for additional coverage as set forth below.

If you are the spouse of a Participant and you are covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following four (4) reasons:

- The death of your spouse entitles you to up to 36 months of continued benefit coverage;
- Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with a contributing employer, entitles you to up to 18 months of continued benefit coverage;
- Divorce or legal separation from your spouse entitles you up to 36 months of continued benefit coverage; or
- Your spouse becomes covered under Medicare entitles you to 18 or 36 months of continued benefit coverage depending upon the qualifying event. (Note: enrollment in Medicare is not a second qualifying event if it would not have caused a loss of coverage absent the first qualifying event).

Dependent children of a Participant covered under the Plan shall have the right to choose continuation of coverage if coverage under the Plan is lost for any of the following five (5) reasons:

- The death of the Participant, entitles the dependent child(ren) up to 36 months of continued benefit coverage;
- The termination of the Participant-parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment with a contributing employer, entitles the dependent child up to 18 months of continued benefit coverage;
- Parent's divorce or legal separation, entitles the dependent child(ren) up to 36 months of continued benefit coverage;
- The Participant-parent becomes covered under Medicare, entitles the dependent child(ren) to 18 or 36 months of continued benefit coverage depending upon the qualifying event; or
- The dependent ceasing to be a "dependent child" under the terms of the Plan, entitles the dependent child(ren) to 36 months of continued benefit coverage.

PLEASE NOTE, the duration of an extension of benefits due to your death and/or a Disability or Workers' Compensation leave will decrease this 18 or 36 month COBRA period by the number of months of your extension of benefits. For example, if you take a leave from covered employment for 6 months due to a non-occupational injury and you fail to return to work, the period of allowable COBRA coverage will be reduced from 18 to 12 months. You are urged to contact the Fund Office if you leave covered employment due to a leave for Disability and/or Workers' Compensation.

A child born or placed for adoption with a Participant during the period of the Participant's continuation coverage is also eligible for COBRA coverage. Once the newborn or adopted child is enrolled for COBRA coverage, he/she will be treated like all other COBRA "qualified beneficiaries". A qualified beneficiary is defined as an employee, a spouse, a dependent child born to or adopted by the employee who is covered under the group health plan the day before the event that triggered the need for COBRA coverage. A new spouse of a Participant who is receiving COBRA continuation coverage may also be enrolled for COBRA coverage pursuant to the Plan's enrollment rules for new spouses.

An 18 month period of COBRA coverage may be extended for up to eleven (11) months (for a total of twenty-nine [29] months of COBRA coverage) if the covered individual has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the Participant's termination or reduction in hours. The individual must notify the Fund within sixty (60) days of the date of the Social Security Administration's disability determination and, in all cases, before the end of the eighteen (18) month continuation period. There will be an increase in the cost for the disability extension of coverage to 150% of the cost to the Plan to cover a similarly situated Participant.

The eleven (11) month disability extension also will apply if the covered person becomes disabled at any time within the first sixty (60) days of his/her initial eighteen (18) month period of continuation coverage, provided that the Fund is timely notified of the disability determination, as described above.

If the conditions for the eleven (11) month extension are met, the eleven (11) month extension is also available to a disabled qualified beneficiary's non-disabled family members who are entitled to COBRA coverage.

Additional qualifying events, called second qualifying events, may occur while an eighteen (18) month period of COBRA continuation coverage is in effect. In these instances, an eighteen (18) month period of COBRA continuation coverage may be extended for up to thirty-six (36) months. For example, if you die or you and your spouse divorce or legally separate during an eighteen (18) month continuation of coverage period, your spouse and eligible dependent children may extend their coverage or, if one of your children ceases to be a "dependent child" under the terms of the Plan, he or she may extend their coverage. If entitlement to Medicare occurs after the Participant terminates employment, then Medicare coverage must be evaluated as if the first qualifying event had not occurred. If Medicare entitlement would not have caused you to lose coverage while an active Participant, it will not be an event that would be considered a second qualifying event. If entitlement to Medicare occurs within eighteen (18) months before the Participant terminates employment or losses coverage due to reduced hours, then COBRA may be extended to his/her spouse and dependents for the longer of eighteen (18) months from the date of termination of employment or a reduction in hours or thirty-six (36) months from the date of Medicare entitlement. Second qualifying events may extend an eighteen (18) month period of COBRA coverage to up to a total of thirty-six (36) months, but in no event will coverage extend beyond thirty-six (36) months after the loss of coverage due to the initial qualifying event. Moreover, you, your spouse or dependent must notify the Fund, as provided above, if a second qualifying event occurs during your continuation coverage period.

Your COBRA coverage will end before the expiration of the 18, 29 or 36 month period for any of the following eight (8) reasons:

- The Plan no longer provides group health coverage;
- Your continuation coverage premium is not timely paid in full;
- A qualified beneficiary becomes covered under another group health plan, after electing continuation coverage;
- The qualified beneficiary becomes covered under Medicare benefits (under Part A, Part B or both or a Medicare Advantage Plan) after election of continuation coverage;
- Coverage has been extended for up to twenty-nine (29) months due to disability and/or there has been a final determination that the individual is no longer disabled;
- If your employer stops participating in the Plan after you become eligible for COBRA, your COBRA coverage will end on the date your employer

establishes a new plan, or joins an existing plan that makes health coverage available to a class of employees formerly covered under this Plan.

- For any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud);or
- The Plan is terminated.

If the continuation coverage terminates earlier than the maximum continuation period available, you will receive a Notice of Termination of Continuation Coverage. This notice will state the reason why the coverage is terminated early, the date coverage will end, and any rights the beneficiary may have to elect an alternative group or individual coverage.

Reasonable Procedures for Notice from Employees or Qualifying Beneficiaries

You, your eligible spouse or eligible dependent child must inform the Fund and/or the Fund's COBRA Administrator, in writing, at the address on page 2 of this Summary Plan Description, of the commencement or termination of a Social Security disability; a divorce or legal separation; or the date a dependent ceases to be covered under the Plan as a dependent. The individual must give this notice within sixty (60) days of the later of: 1) the date of the event; 2) the date on which coverage would end under the Plan because of the event; or 3) the date on which the individual is informed, by means of the Plan SPD or the general notice of COBRA rights, of the individual's obligation to provide notice and the procedure for providing the notice.

Your employer has the responsibility to notify the Fund within 30 days in writing, to the address on page 2 of this Summary Plan Description, of the date of your death, termination of employment, reduction in hours of employment or your coverage under Medicare.

If you or your eligible spouse or dependent or employer fail to give timely written notice of the qualifying event within the time periods specified above and as a result, the Fund pays a claim for a person whose coverage terminated due to a qualifying event and who does not elect COBRA coverage under this provision, then the Participant or dependent or the Employer, as appropriate, must reimburse the Fund for any claims that should not have been paid. If a Participant or dependent fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the individual was his or her dependent or the Trustees may, in their sole discretion, initiate a lawsuit to collect the amount due.

When the Fund and/or the Fund's COBRA Administrator is notified of one of these events, you will be notified, in writing, that you have the right to choose COBRA coverage, or that the Fund has determined that you are not eligible for the requested continuation coverage. If it is determined that you are not eligible for continuation coverage, the Fund will provide you with a Notice of Unavailability

of Continuation Coverage, which will provide an explanation of why you are not entitled to the coverage.

Under the law, you or your eligible dependent must inform the Fund, in writing, that you want COBRA coverage within sixty (60) days of the later of:

- The date you or your eligible dependent ordinarily would have lost coverage because of one of the events described above, or
- The date you receive notice of your right to elect continuation coverage.

If you do not timely and properly choose COBRA coverage, your group health coverage under the Plan will end.

If you choose COBRA coverage, you are entitled to coverage that is identical to the coverage being provided under the Fund to active Participants (or their eligible dependents) except the Life Insurance, Accidental Death & Dismemberment Insurance and NYS Disability benefits, where applicable, will not be provided. You have the right to convert your Group Term Life Insurance to an individual Life Insurance policy. You must contact the Fund Office for further details on your right to convert the Group Term Life Insurance Benefit to an individual policy.

COBRA Payment Provisions

COBRA coverage requires timely monthly payments. The payment due date is the first day of the month. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA coverage must include payment for the period of time dating back to the date you lost coverage due to a qualifying event. The initial COBRA payment is due 45 days from the date COBRA continuation coverage is elected. Thereafter, COBRA allows for a grace period of thirty (30) days to pay any subsequent amounts due. If you fail to make the full payment by each due date (or within the thirty day grace period), COBRA coverage terminates.

The Trustees will determine the cost for COBRA coverage. The cost will not necessarily be the same as the amount of the monthly contribution that an Employer makes on behalf of a covered employee. The cost will be fixed, in advance, for a 12 month period.

Once a timely election of COBRA coverage has been made, it is your responsibility to make timely payment of all required payments. The Fund will not send notice that a payment is due or that it is late, or that COBRA coverage is about to be terminated due to failure to make a timely payment.

COBRA coverage is subject to your eligibility for coverage under the Plan. The Board of Trustees reserves the right to terminate your COBRA coverage, retroactively, if you are determined to be ineligible. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

COBRA Coverage and Extension of Benefits for Your Death, Disability and Workers' Compensation Leaves

As noted earlier in this book, any period of extended coverage, due to your death or your inability to work due to a disability and/or Workers' Compensation leave, will be deducted from the applicable COBRA coverage period (i.e., six months of extended coverage due to disability will reduce the 18 month maximum COBRA coverage to a maximum of twelve (12) months). However, you and your eligible dependents receiving COBRA coverage may be entitled to an 11 month extension of COBRA allowing, for up to a maximum of 29 months of COBRA coverage, if the Social Security Administration determines you are totally disabled.

Please be advised, you do have other options for health care coverage under the Affordable Care Act and the Health Insurance Marketplace.

What is the Health Insurance Marketplace?

You may be able to obtain coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can know what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace, as this is a "special enrollment" event. **After 60 days, your special enrollment period will end and you may not be able to enroll.** There are open enrollment periods when anyone can enroll in Marketplace coverage, but you might have to wait. <u>Therefore, it is in your best interest to act right away if you lose your coverage under the Plan.</u>

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during the open enrollment period. You can also terminate your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child, through the special enrollment period that was described above. **If you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage.** Once you have exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period. If you sign up for Marketplace coverage in lieu of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You can access the Marketplace for your state at www.HealthCare.gov or call 1-800-318-2596.

What factors should be considered when choosing coverage options?

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have any questions about COBRA continuation coverage, please contact the Fund Office at 425 Merrick Ave, Westbury, NY 11590 or telephone (516) 214-1300; or contact Associated Administrators, LLC, the Fund's COBRA Administrator, at P.O. Box 1095, Sparks, MD 21125-1095 or telephone 1-855-266-1500.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA CERTIFICATES

If your employment terminates and you were covered under the Plan at that time and/or your COBRA coverage terminates, you have the right to receive a certificate of prior creditable coverage, pursuant to HIPAA, upon request. You may also request this certificate while you are still covered under the Plan and for up to 24 months after your termination. This certificate should be presented to your future employer or insurance company as proof of prior creditable coverage. Please contact the Fund Office for further information.

HIPAA PRIVACY NOTICE

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), the Fund has adopted policies to safeguard the Protected Health Information (hereinafter "PHI") of all Participants and beneficiaries. A copy of such policies is provided by the Fund as a separate document. If you have any questions regarding the Fund's policies or wish to request such policies, contact the Fund Office.

The privacy regulations of HIPAA require confidentiality of your PHI. PHI includes all individually identifiable health information related to your past, present, or future physical or mental health condition or to payment for health care that is maintained by the Plan or on behalf of the Plan, in connection with the Plan's provision of medical, dental, vision or pharmacy benefits. This means that unless you authorize, in writing, that your PHI be released to specific individual(s) (i.e., if you wish your spouse or child to be able to discuss any matter relating to your claims), the Fund and its providers will not be able to respond to an individual who makes an inquiry or wishes to discuss your claims. You must, therefore, contact the Fund Office and request an authorization to release your PHI. Likewise, the Plan will not disclose your spouse's or adult children's PHI without their written authorization. Once the written authorization is received by the Fund Office, the permitted individual will be able to access your PHI and, in turn, be able to discuss any claim within the scope of that written authorization.

Under Federal Law, you have certain rights with respect to your PHI, including a right to see and copy the information, the right to receive an accounting of certain disclosures, when you so request, and in certain instances, amend the information. You also have the right to request that reasonable restrictions be placed on the disclosure of your PHI.

Pursuant to HIPAA, the Fund has designated a Privacy Officer, who is named in the privacy notice issued by the Fund. The function of the Fund's Privacy Officer is to ensure compliance with the Fund's privacy policies and procedures by Fund employees and to accept and investigate any complaint made against the Fund by a Participant or beneficiary. If you wish to file a complaint for an alleged violation of your PHI, contact the Fund's Privacy Officer or you may file a complaint with the United States Secretary of Health and Human Services. If you have any questions regarding the Fund's privacy policies, contact the Fund Office.

ERISA RIGHTS AND PROTECTIONS

Your Rights Under ERISA

As a Participant in the U.F.C.W. Local 1500 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 sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly, Pension and Welfare Benefit Administration).

Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Fund may make a reasonable charge of the copies.

Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each Participant with a copy of a summary of the annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Upon request, you will be provided a certificate of prior creditable coverage, free of charge, from your group health plan or health insurance issuer when the following circumstances occur: (1) you lose coverage under the Plan; (2) when you become entitled to elect COBRA continuation coverage; (3) when your COBRA continuation coverage ceases; (4) if you request it before losing coverage; (5) or if you request it up to 24 months after losing coverage. Without evidence of prior coverage, you may be subject to an open enrollment period which could preclude you from obtaining 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 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 limits.

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 Trustees 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 Trustees. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the 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 Fund Office. 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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The toll-free telephone number is 1-866-444-EBSA (3272).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or **www.insurekidsnow.gov** to find out how to apply. In New York, you can call the New York State of Health at **1-877-KIDS NOW.** If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. On the following pages you will find contact information for each State.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the states listed below, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Health First Colorado Website: http://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 771	Website: http://www.dhs.iowa.gov/hawk-i Phone: 1-888-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov//provider/medicalassistance/healthinsurancepremiumspaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.me.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: http://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits
Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare &
Medicaid Services

www.cms.hhs.gov
1-877-267-2323,
Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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