LOCAL 817 IBT THEATRICAL TEAMSTERS WELFARE FUND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2023

LOCAL 817 WELFARE FUND

817 Old Cuttermill Road
Great Neck, NY 11021
Phone: 516-365-3470
Fax: 516-365-2609
817benefits.org

The Local 817 Welfare Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

Union Trustees

Thomas J. O'Donnell
817 Old Cuttermill Road
Great Neck, NY 11021

Francis J. Connolly, Jr.
817 Old Cuttermill Road
Great Neck, NY 11021

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Fund Manager

Kathleen Kreinbihl

Fund Auditor

MSPC CPA

Fund Counsel

Friedman & Anspach

Fund Consultant and Actuary

Segal

IMPORTANT NOTE

This document, together with the Certificates of Coverage issued by Aetna, constitutes the Summary Plan Description (SPD) and replaces and supersedes all other plan documents, SPDs and amendments previously issued.

For Help or Information – Quick Reference Chart

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
INFORMATION NEEDED	**WHOM TO CONTACT**
General Plan Information and Eligibility • **Eligibility** • **Enrollment Form and Request Enrollment** • **Information about COBRA and special enrollment, including premium payments and notices** • **Information about your rights under various laws when you are a veteran, are on a FMLA leave, or need to cover a dependent child under a medical support order** • **Request documents or other Plan related information** • **Claim Forms** • **General questions about Plan coverage** • **COBRA Administration** • **Information About Coverage** • **Adding or Dropping Dependents** • **Cost of COBRA Continuation Coverage** • **COBRA Premium payments**	**Fund Manager** Local 817 IBT Theatrical Teamsters Welfare Fund 817 Old Cuttermill Road Great Neck, NY 11021 Telephone: 516-365-3470 Fax: 516-365-2609 Website: 817benefits.org

QUICK REFERENCE CHART	
INFORMATION NEEDED	**WHOM TO CONTACT**
Medical/Hospital • **ID Cards** • **Choice POS II** • **Medical Network Provider Directory** • **Additions/Deletions of Providers** • **Out-of-Network Claim forms** • **Plan Benefit Information**	**Aetna** Aetna Life Insurance Company 151 Farmington, Avenue Hartford, CT 06156 Telephone: Members call the number on your ID card. All others call 888-98-AETNA (888-982-3862) www.aetna.com
Dental Benefits • **Dental Network and Provider Directory** • **Dental Claims and Appeals**	
Prescription Drug Benefits • **ID Cards** • **Retail Network Pharmacies** • **Mail Order (Home Delivery) Pharmacy** • **Prescription Drug Information**	**OptumRx** OptumRx, Inc. 1600 McConnor Parkway Schaumburg, IL 60173-6801 Telephone: 866-328-2005 (TTY 7711) www.optumrx.com Mail Order: OptumRx P.O. Box 2975 Mission, KS 66201 Telephone: Members call the number on your ID card

QUICK REFERENCE CHART	
INFORMATION NEEDED	**WHOM TO CONTACT**
Vision Care Benefits • **Vision Network and Provider Directory** • **Vision Claims and Appeals**	**Davis Vision** Capital Region Health Park Suite 301 711 Troy-Schenectady Road Latham, NY 12110 Telephone: 800-999-5431 www.davisvision.com Hours of Operation: 8:00 am – 11:00 pm Mon-Fri, 9:00 am – 4:00 pm Saturday, 12:00 pm – 4:00 pm Sunday Automated support 24/7 **For Out-of-Network Claims:** **Local 817 IBT Theatrical Teamsters Welfare Fund** 817 Old Cuttermill Road Great Neck, NY 11021 Telephone: 516-365-3470 Fax: 516-365-2609
Life Insurance and Accidental Death and Dismemberment Benefits • **To initiate a claim or to change and/or update beneficiary information, contact the Fund Office**	**Fund Manager** Local 817 IBT Theatrical Teamsters Welfare Fund 817 Old Cuttermill Road Great Neck, NY 11021 Telephone: 516-365-3470 Fax: 516-365-2609 Website: 817benefits.org
Short-Term Disability Benefits/Weekly Accident and Sickness Benefits • **File claims**	
Plan Manager and HIPAA Privacy and Security Officer (for COBRA and Self-Insured Benefits)	

This Plan contains Coordination of Benefits (COB) provisions to prevent double payment of certain covered expenses. This provision works by coordinating the benefits under this Plan with other plans in which a person is a participant so that total benefits available will not exceed one hundred percent of allowable expenses. See the *Other Information You Should Know* and the *Coordination of Benefits* sections of this document for details.

You will be provided with a Certificate of Coverage for each of the benefits provided by the Plan upon request. Please refer to the Certificate of Coverage/Summary of Benefits provided by The Hartford for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage for Life and AD&D, and Weekly A&S, as well as how and where to file a claim and appeal. This document, together with the Certificates of Coverage and the Summary of Coverage, constitute the Summary Plan Description. If there are any discrepancies between this booklet and any Certificate, the Certificate will govern.

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INTRODUCTION

The Local 817 IBT Theatrical Teamsters Welfare Fund has established a Plan that is designed to help you and your family afford proper health and dental care. The Plan also provides active participants with holiday and vacation benefits, life and accident insurance coverage, as well as a weekly accident and sickness benefit, and retirees with life insurance.

This Summary Plan Description describes the medical, dental, prescription drug, optical, short-term disability, life insurance, accidental death and dismemberment insurance and retiree coverage.

This document is effective January 1, 2023 and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants. Plan benefits are designed to help cover many of your expenses when you become sick or are injured. Below is a summary of how the Plan works.

- **Medical and Hospital Coverage.** Your hospital and medical benefits are self-insured and administered by Aetna.
- **Prescription Drug Coverage.** Your prescription drug benefits are self-insured and administered by OptumRx.
- **Dental Coverage.** Your dental benefits are self-insured and administered by Aetna.
- **Optical Benefits.** Your optical benefits are self-insured and administered by Davis Vision. Optical benefits are payable for eye exams, eyeglasses, contact lenses and laser vision surgery. Benefits depend on whether you go to your own provider or use a participating vision care center.
- **Short-Term Disability Benefits (Weekly Accident and Sickness (A&S) Benefits).** Your Weekly A&S benefits are insured and administered by The Hartford. Short-term disability (STD) benefits provide a source of income if you become unable to work due to a non-work-related injury or illness. The STD benefit replaces part of your base pay, based on the New York or New Jersey state disability benefit laws, for up to 26 weeks of disability.
- **Life Insurance Benefits**. Your Life Insurance benefits are insured and administered by The Hartford. You have $50,000 of life insurance coverage as an active participant, or $10,000 of life insurance coverage as a retiree. Your life insurance benefit is payable to your spouse or other beneficiary after your death.
- **Accidental Death and Dismemberment Insurance Benefits.** Your Accidental Death and Dismemberment Insurance benefits are insured and administered by The Hartford. For active participants, you have $50,000 of accidental death and dismemberment (AD&D) insurance coverage. The Hartford pays $50,000 to your beneficiary if you die in an accident (in addition to the life insurance benefits described above). If you are seriously injured in an accident, the Hartford pays either $25,000 or $50,000 (depending on the severity of the injury) to you.
- **Retiree Coverage.** The Fund provides retirees who meet the eligibility requirements with

life insurance, as well as health and dental benefits as applicable.

This document describes your benefits, as well as eligibility rules and the procedures for filing claims and appeals. We urge you to become familiar with your benefit program and to keep this booklet for future reference.

To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility section in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status as deemed satisfactory to the Plan. Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

This document will help you understand and use the benefits provided by the Local 817 IBT Theatrical Teamsters Welfare Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the *What's Not Covered* and *Glossary* sections.

We have tried to use everyday language to explain how each benefit works; however, there are certain technical terms that apply to each benefit. These terms are defined throughout the document and in the "Glossary" at the back of the document.

While this booklet summarizes the major features of the Plan, it does not contain each and every provision. Complete details of medical and hospital coverage are described in Certificates of Coverage issued by Aetna. Complete details of the Weekly Accident & Sickness and Life and AD&D benefits are described in the Certificates of Coverage issued by The Hartford, which will be sent to you free-of-charge upon request. It is also important to note that not every expense you incur for health care is covered by this Plan. If you have questions about your coverage or your obligations under the terms of the Plan, please contact the Fund Office.

As your Trustees, we make every effort to administer the Trust carefully and we make changes to your Plan as the Trust's financial condition changes. Eligibility provisions, cost-sharing and benefits may be increased or decreased from time to time. You will be notified if there are changes to the Plan. If these later notices describe a benefit or procedure different from what is described in this booklet or in the Certificates of Coverage, you should rely on the later information. Keep this document with notices of Plan changes in a safe and convenient place for reference.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

While we have made every effort to ensure that what you find here accurately reflects the certificates, should there be any discrepancy between these summaries and the Certificates of Coverage, the Certificates will govern.

If you have any questions about the information in this booklet, please call the Fund Office at 516-365-3470.

Sincerely,

Board of Trustees

ACA SECTION 1557 NOTICE OF NONDISCRIMINATION

DISCRIMINATION IS AGAINST THE LAW

The Local 817 IBT Theatrical Teamsters Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Local 817 IBT Theatrical Teamsters Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Local 817 IBT Theatrical Teamsters Welfare Fund provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Kathleen Kreinbihl at the number below.

If you believe that the Local 817 IBT Theatrical Teamsters Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kathleen Kreinbihl
Local 817 IBT Theatrical Teamsters Welfare Fund
817 Old Cuttermill Road
Great Neck, NY 11021
Phone: 516-365-3470
Fax: 516-365-2609

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kathleen Kreinbihl, Fund Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800-868-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	Message About Language Assistance
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
3. French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
4. Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
5. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
6. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
7. Arabic	ظوحلم: اذإ تنك تحتدت ثدحتا ركذا رفاوتت ةيوغللا ةدعاسملا تامدخ نإف، ةغللا ناجملاب كل . مقر(مقرب لصتا. Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470:مكبلاو مصلا فتاه
8. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470 번으로 전화해 주십시오.
9. Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
10. Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
11. Urdu	لاک ۔ نیہ بایتسد نیم تفم تامدخ یک ددم یک نابز وک پآ وت، نیہ ےتلوب ودرا پآ رگا :رادربخ نیرک Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
12. Yiddish	.לאצפא זוף יירפ סעסיוורעס פליה רַארפש רייא ראפ ואהראפ זענעז, שידיא טדער ריא .טפור :ביוא . Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
13. Bengali	লয্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল◌ ◌আছ। ◌ফান করন ১- Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
14. French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.
15. Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para Aetna 800-370-4526 TTY: 711; OptumRx 866-328-2005 TYY 7711; Fund Office 516-365-3470.

ELIGIBILITY AND ENROLLMENT

Initial Eligibility for Coverage

Employee Eligibility. If you are an employee of a Contributing Employer who has entered into a bargaining agreements with the Local 817 IBT Theatrical Teamsters Welfare Fund working in a benefits-eligible position your eligibility for coverage begins on the February 1st following the year in which you have worked at least 200 day units of work in covered employment with contributing employers during the immediately preceding calendar year. If contributions are received on your behalf by the Fund Office for 200-day units of work in covered employment by the end of November of the calendar year, coverage begins on January 1st following year in which you worked the 200-day units of work. If you are working "steady employment" and are considered a permanent employee, your coverage begins on the first day of such employment. Your coverage will last for 12 months from the date you are first eligible as long as you remain a permanent employee.

A "Contributing Employer" is an employer that is required under a collective bargaining agreement to contribute to the Local 817 Welfare Fund on your behalf. If you work for a Contributing Employer, all work you do for that employer is considered "Covered Employment." You are also eligible if you are an employee of Local 817 IBT or an employee of Local 817 IBT Pension, Welfare, or Scholarship Funds. Once you become eligible for coverage, you will be considered a participant in the Plan.

Your health and welfare benefits with the Local 817 IBT Theatrical Teamsters Welfare Fund are not vested.

Continuing Coverage. Your coverage continues each year provided you continue to work at least 200 day units of work in covered employment during the immediately preceding calendar year.

Special Rule for Weekly Loss of Time Disability Benefits. If you work for a contributing employer in New York or New Jersey and you are not eligible for any benefits provided by the Fund, you will still be covered for Weekly Loss of Time disability benefits according to the terms and conditions of the New York Disability Benefits Law and the New Jersey Temporary Disability Benefits Law.

A "day unit" is a separate period of employment during each day, night, holiday or call-in period. You cannot accrue more than two-day units during a 24-hour period.

Retiree Eligibility. See the section entitled "When You Retire" for details on eligibility and benefits available for retired participants.

Dependent Eligibility. Your eligible dependent's coverage begins on the date your coverage begins provided you properly enroll them. If you acquire a dependent after that date, your dependent's coverage begins when he/she meets the definition of dependent provided you properly enroll him/her within the necessary timeframe.

Your eligible dependents include your:

- **Spouse.** Your spouse is your lawfully married spouse.
- **Child(ren).** Your child(ren) are covered until the end of the month in which the child reaches age 26 regardless of student status, marriage or residency and even if an adult child is eligible for their own employer sponsored health insurance coverage. Covered children include:
  - Your biological child(ren).

- Your lawfully adopted child(ren) or child(ren) placed for adoption. If you have started legal adoption procedures, the child is considered a dependent if he/she lives with you full-time and depends on you for support. If you are adopting a child from birth, the child is considered a dependent from birth as long as you take physical custody of the child and you file a petition to adopt within 31 days after birth. The child will not be covered under this Plan if the child's biological parent has coverage available for the child's care, a notice has been filed revoking the adoption, or one of the natural parents revokes their consent to the adoption. Your newborn child who is placed for adoption with you within 31 days after the child was born will be covered from the date the child was placed for adoption.
- Your stepchild(ren).

You may also cover dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). See below for more information on QMCSOs and NMCSNs.

No individual may be covered under this Plan both as an employee or retiree and as a dependent. No individual may be covered under this Plan as both an employee and a retiree.

- **Disabled children.**
  - Coverage shall be provided for any unmarried child over the age of 26 who is dependent on you for support and maintenance, who is incapable of self-sustaining employment because of mental or physical disability (as defined below) and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. In order to be eligible for this extension, the disability must have existed, and the child must have been covered continuously by the Plan up to and including, the day before their 26th birthday.

  Proof of the above disability must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age. You are also required to provide proof of financial dependence to the Fund Office within the same time period.

  Coverage will cease:

  - Due to cessation of "disability";
  - For failure to give proof that the disability continues, if requested;
  - For failure to submit to any required exam, as requested;
  - When Dependent marries, is capable of self-sustaining employment or is no longer financially dependent on you for support and maintenance.
  - Aetna will have the right to require proof of the condition of the disability. Aetna also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after two (2) years from the date your child reached the maximum age.

Enrolling for Coverage

Initial enrollment. When you first become eligible for benefits, you must enroll for coverage to begin. In order to enroll yourself and your dependents, you must complete and sign an enrollment form, including a beneficiary designation, and return it to the Fund Office within 60 days of the date you are first eligible for coverage.

If you have eligible dependents, you must enroll them when you are first eligible in order for them to be covered and provide the necessary proof of dependent status as listed below. If the Fund Office does

not receive a completed enrollment form and the documentation listed below within 60 days, your dependents will not be eligible for benefits. If you acquire a new dependent after you are initially eligible for benefits, you will also need to complete an enrollment form to add him or her and provide proof of dependent status. If you do not submit the required documents to the Fund Office within 60 days of your Initial Eligibility, you may enroll late but coverage will be delayed subject to "Late Enrollment" procedures described below.

You and your dependents may decline/opt out of enrollment in medical, dental, and vision coverage under this Plan for yourself, but to do so, you must submit an affidavit to the Fund Office. Remember that a Dependent may not be enrolled for coverage unless you (the employee) are also enrolled. If, at a later date, you want the coverage you declined for yourself you may enroll only under the Special Enrollment provisions (when applicable) or the Late Enrollment provisions described later in this section. All forms are available from the Fund Office. Note that no additional compensation is paid to you if you waive/decline benefit coverage.

The Fund Office will accept a copy of the following documents as proof of dependent status:

- **Spouse (Marriage):** Copy of the certified marriage certificate and Social Security card. If your spouse is employed, you must also provide a letter from your spouse's employer stating that there is no other insurance available. If other coverage is available and your spouse is enrolled, you must provide a copy of both sides of the insurance card.
- **Child (Birth):** Copy of the certified birth certificate and Social Security card.
- **Step-Child:** Copy of the child's certified birth certificate and social security card and a copy of the divorce decree from your spouse's former marriage (if applicable) to determine responsibility for providing medical coverage and a marriage certificate between you (the participant) and the child's natural or adoptive parent.
- **Adoption or Placement for Adoption:** Copy of court order signed by a judge.
- **Unmarried, Disabled Dependent Child:** Written statement from the child's physician indicating the child's diagnoses are the basis for the physician's assessment that the child is totally disabled (as that term disabled is defined in this document), and is incapable of self-sustaining employment as a result of that disability, and dependent chiefly on you and/or your spouse for support and maintenance. Aetna may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document.

Special Enrollment Rights

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent. However, you must request the enrollment after the marriage, birth, adoption or placement for adoption within 60 days of the marriage, birth, adoption or placement for adoption and complete the enrollment forms and provide proof of dependent status in accordance with the procedures described above.

If you decline enrollment for (or do not enroll) yourself and/or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan at a later date if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage), provide proof of the loss of the other coverage and complete an enrollment card to enroll the dependents.

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

Late Enrollment

You may enroll your dependents in the Plan late (after 60 days), but benefits will not begin until the month following the month in which the Fund Office receives your completed enrollment material along with the necessary proof.

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

When Coverage Ends

Your coverage. Your coverage normally ends on the earliest of the following dates:

- the date you fail to meet any of the Fund's eligibility requirements;
- the January 31st (or December 31st if your coverage began on January 1st) following the year you fail to accumulate 200 day units with contributing employers during a calendar year;
- the date the Fund or any benefit it offers terminates;
- the date the Fund is amended to terminate coverage for your employment category; or
- the date of your death.

Dependent coverage. If your dependents are enrolled for Plan coverage, their coverage will normally end on the earliest of the following dates:

- the date you (the participant) are no longer eligible (for any reason);
- the date the dependent no longer meets the definition of a "Dependent" under the Fund (for children, this will be the end of the month the child reaches age 26);
- the date the Fund or any benefit it offers terminates;
- the date the Fund is amended to terminate coverage for a category to which the dependent belongs;
- with respect to a spouse, the date you and your spouse are legally separated or divorced.

Disability Credit. If, after you have established your eligibility under this Plan, you cannot work because of disability and are receiving Weekly Loss of Time or Workers' Compensation benefits, the Fund will grant you one-day unit of credit toward your continued eligibility for each day you are receiving Weekly Loss of Time or Workers' Compensation benefits up to five days a week of credit. You may not be granted more than 200-day units of credit for one calendar year and the credit will not be counted toward continuing benefits. You may not receive credit under this provision for consecutive years. You must regain eligibility under the Plan in accordance with the eligibility rules in order to become eligible for this provision again.

Rescission of Coverage

Your coverage may be terminated retroactively (rescinded) due to any of the following:

- In cases of fraud or intentional misrepresentation (you will be provided with 30 days advanced

notice); or

- Non-payment of premiums (including COBRA premiums). Failure to notify the Fund Office within 60 days of a divorce or of a child aging out of the Plan will be considered a non-payment of COBRA premiums. Coverage will be terminated retroactively to the date of the event, and you will be responsible for any claims paid from the date of the event.

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed in federal Treasury Regulations. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative record keeping if the Participant does not pay any premiums for coverage after termination of benefits under the Plan.

A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contribution toward the cost of coverage (including COBRA premiums). A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the date of divorce.

Reinstatement of coverage. If your benefits terminate, you will have to meet the eligibility rules describe above to reinstate your benefits.

Keeping the Fund Informed

The best way to ensure fast and accurate claims payment is to make sure the Fund Office has the most up-to-date information for you and your eligible dependents. In particular, please contact the Fund Office whenever you or your spouse:

- change your name
- change your address
- add an eligible dependent
- change telephone number or e-mail address
- change marital status (marriage, legal separation or divorce)
- or in the case of death.

We're Here To Help!
If you have any questions about eligibility for Welfare Fund benefits, please call the Fund Office at 516-365-3470 during normal business hours.

Qualified Medical Child Support Orders (QMCSOs). If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment, decree or order issued by a state court or agency that creates or recognizes the existence of an eligible child's right to receive health care coverage. The Order must comply with applicable law and must be approved and accepted as a QMCSO by the Plan Administrator in accordance with Plan procedures. Contact the Fund Office for more information (free of charge) about the Plan's QMCSO qualification procedures.

In the Event of Your Death

If you are an active participant and eligible for medical coverage or a retired participant who currently receives a life insurance benefit from the Fund, on the date of your death, your beneficiary will receive a life insurance benefit (and an AD&D insurance benefit, if you are an active member and your death is accidental). See pages 82 and 84 for more information about life and AD&D insurance benefits.

Health benefits continue for your surviving spouse and dependent children after your death until the earlier of:

- Twelve (12) months from the date of your death (active participants);
- For a spouse, the date of remarriage (retired participants);
- For dependent children, the date they are no longer eligible due to age (active and retired participants); or
- The date the Fund or any benefit it offers terminates.

Following this continuation period, your surviving dependents may be eligible for COBRA Continuation Coverage. See the COBRA section for more information.

In the event of your death, your spouse or beneficiary should:

- notify the Fund Office
- provide the Fund Office with a copy of your death certificate
- apply for your life insurance (and AD&D insurance, if applicable)
- if your dependents want to continue coverage under the Plan, enroll for self-pay COBRA Continuation Coverage.

If You Enter the Uniformed Services – Leave for Military Service (USERRA)

The Fund complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). This legislation guarantees certain rights to individuals called to active duty in the armed forces of the United States.

A participant who enters military service will be provided continuation and reinstatement rights in accordance with USERRA, as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA continuation coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that he or she has been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is in the Plan Facts section on page 143) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for his/her dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA; therefore, either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same time frames as permitted under COBRA.

Paying for USERRA Coverage:

- If you (the employee) go into active military service for up to 31 days, you (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.
- If you (the employee) elect USERRA temporary continuation coverage, you (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date the employee stopped working. Except for the exceptions noted above, USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works the same as COBRA coverage. See the COBRA chapter for more details.

USERRA allows the employee to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage under the self-pay rules of this Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan. You should contact the Fund Office to discuss the effects of this choice when you first go into military service.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces: When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the

employee returns to employment within:

- 90 days from the date of discharge from the military if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight (8) hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office.

You should notify the Fund Office when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

If You Take a Family and Medical Leave

The Family Medical Leave Act (FMLA), 29 USC §2601 et esq. provides that if you work for an employer covered by that Act you are entitled to unpaid leave up to 12 weeks of unpaid leave during any 12-month period for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a spouse, child or parent who is seriously ill or for your own illness or up to 26 weeks to provide care for a covered service member. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms in which you may be entitled to it, contact your Employer.

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund.

IMPORTANT

The Fund will maintain your eligibility status until the end of the leave, provided that the contributing employer properly grants the leave under the FMLA (or other state-mandated leave that requires continuation of coverage) and the contributing employer makes the required notification and contributions. Please call your employer to determine whether you are eligible for FMLA leave and/or state-mandate leaves except for New York Paid Family Leave. For information on New York Paid Family Leave, you may contact the Fund Office.

When You Retire

Coverage for you and your dependents will end under the active Plan when you retire. However, if you meet the eligibility requirements described below, you may be eligible for retiree coverage.

Eligibility. You are eligible for retiree coverage in this Plan if you are eligible for Welfare Fund benefits under the Plan when you retire, you have qualified for Welfare Fund benefits as an active participant for 30 or more years without a break in units, and you retire under the Local 817 Pension Plan on a Regular, Early, or Disability pension. If you retire on a Disability Pension, your eligibility continues until you become eligible for Medicare. In determining eligibility, Pension Credits earned prior to January 1st, 2019 can be counted towards eligibility, as long as there is no break in units. A break in units occurs if you have two consecutive years where you earn less than 50 units towards Welfare eligibility, or, for Pension Credits earned before January 1st, 2019, two consecutive years in which you earn less than 50 units towards a Pension Credit. Once there is a break in units, all years prior to the break will cannot count towards eligibility for retiree coverage.

If you retire on a Vested Pension, you are not eligible for retiree health coverage. In this case, you are only eligible for life insurance coverage if you currently receive medical benefits from the Fund. You must be a covered participant receiving medical benefits through the Plan prior to your retirement in order to be eligible for life insurance coverage. See the section entitled "When You Retire" for details on eligibility and benefits available for retired participants.

Health Benefits for Retirees

- If you are an eligible retiree, you and your dependents, who are not yet age 65 or otherwise eligible for Medicare, are eligible for the same health benefits you were eligible for immediately before your retirement. Please note that benefits end for retirees who retire on a Disability Pension once Medicare benefits begin. Your spouse is only eligible if you have been married at least 12 months prior to retirement.
- If you are an eligible retiree and/or a dependent of an eligible retiree and are 65 or otherwise Medicare-eligible, you are eligible for the Medicare Supplemental Program. This Program coordinates with Medicare and pays secondary benefits after Medicare pays benefits. Information about coordination with Medicare begins on page 110.

Other Benefits for Retirees

All eligible retirees (who retire on a Regular or Early Pension and have 30 welfare credits and medical coverage from the Fund) are eligible for the following benefits regardless of age or Medicare-entitlement:

- Life Insurance (retirees are eligible for $10,000 in Life Insurance)
- Dental (same as active participants)
- Optical (same as active participants)
- Prescription Drug (same as active participants)

Please note, these benefits are not available to you if you retire on a disability pension, please contact the Fund Office for more information.

When you retire:

- Notify the Fund Office in advance of your retirement.
- Apply for retiree coverage, if you are eligible.

COBRA CONTINUATION COVERAGE

How COBRA Continuation Coverage Works

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA Continuation Coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the health care coverage provided under this Plan and is available to you and your eligible dependents at your own expense provided your coverage is lost due to a "Qualifying Event."

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include any active participant or eligible dependent who are covered by the Plan when a Qualifying Event occurs. A child who becomes an eligible dependent by birth, adoption, or placement for adoption with the eligible participant during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your spouse during a period of COBRA coverage is not a Qualified Beneficiary.

If you choose COBRA coverage, you and your dependents may continue the same medical, dental, vision and prescription drug coverage that you had prior to the Qualifying Event. COBRA does not cover Weekly Accident and Sickness, Life Insurance and AD&D benefits. You do not have to prove good health to get COBRA coverage. However, you are required to pay the full cost of coverage for both you and any covered dependents (plus a 2% administrative fee).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

PLEASE NOTE: The explanation of COBRA in this section is not intended to give you or your enrolled dependents any rights to COBRA that are not otherwise required by law.

The following chart shows the Qualifying Events and the periods of eligibility for COBRA Continuation Coverage. To be eligible to elect COBRA coverage, you or your dependent must lose coverage due to any one of the following Qualifying Events:

IF YOU LOSE COVERAGE BECAUSE OF THIS QUALIFYING EVENT:	THESE PEOPLE WOULD BE ELIGIBLE FOR COBRA COVERAGE:	FOR UP TO:
Your employment terminates for reasons other than gross misconduct	You and your eligible dependents	18 months (May be extended to 29 months in cases of Social Security Administration disability determination.
You become ineligible due to a reduction in day units	You and your eligible dependents	
You die	Your eligible dependents	36 months

IF YOU LOSE COVERAGE BECAUSE OF THIS QUALIFYING EVENT:	THESE PEOPLE WOULD BE ELIGIBLE FOR COBRA COVERAGE:	FOR UP TO:
You divorce or legally separate	Your eligible spouse and stepchildren	36 months
Your dependent children no longer qualify as dependents	Your eligible dependent children	36 months
You become entitled to Medicare Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. Also note that if you are entitled to Medicare at the time that your employment terminates or you become ineligible due to a reduction in day units and your Medicare entitlement began less than 18 months before the applicable Qualifying Event, your dependents will be eligible for up to 36 months of COBRA after the date of Medicare entitlement.	Your eligible dependents	36 months
Proof of good health is NOT required for COBRA coverage.		

Availability of COBRA Coverage. The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Fund Office has been notified that a Qualifying Event has occurred. Your contributing employer is responsible for notifying the Fund Office of termination of employment, reduction in day units, the death of the employee, or the contributing employer's commencement of a bankruptcy proceeding. However, you or your family should also notify the Fund Office promptly if any such Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

Notification you must give to the Fund. For the following Qualifying Events, you must notify the Fund Office no later than 60 days after the Qualifying Event (or Second Qualifying Event) occurs:

- your divorce or legal separation from your spouse;
- your death or entitlement to Medicare;
- your dependent child no longer meets the definition of eligible dependent (e.g., or your dependent child reaches age 26 or is on longer disabled); or
- you or a dependent ceases to be disabled, as determined by the Social Security Administration.

The notice of occurrence of any of these events or notice of a second Qualifying Events (as described on the previous page) must be provided to the Fund Office in writing and must be made within 60 days after the Qualifying Event or second Qualifying Event (or the date on which coverage would end because of the event, if later). If the Qualifying Event is a divorce or legal separation, you must include a copy of the divorce decree or legal documentation of the legal separation. Other applicable documentation (such as a birth certificate) may also be required.

You or your family member can provide notice on behalf of yourself as well as other family members affected by the Qualifying Event. The written notice of the Qualifying Event should be sent to the Fund Office (817 Old Cuttermill Road, Great Neck, NY 11021), and should include: date; Participant's name, Social Security number/ID number and address; name, date of birth and social security number of dependent(s) who will lose coverage due to event (and address, if different from Participant's);

relationship of dependent(s) to Participant and type and date of event that will cause loss of coverage. The written notice may also include spouse/dependent's employer's name, if applicable.

If you do not notify the Fund Office in writing within the applicable 60-day period or you do not follow the procedures prescribed for notifying the Fund Office, you will lose your right to elect COBRA Continuation Coverage.

Unavailability of coverage. If you or your enrolled dependent has notified the Fund Office in writing of your divorce, your legal separation or a child's loss of dependent status, or a second Qualifying Event, but you or your enrolled dependent is not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same time frame the Plan follows for election notices.

COBRA enrollment. When your employment ends or you have a reduction in day units so that you no longer covered under the Plan, or when the Fund office is notified on a timely basis that you have died, divorced or legally separated, become entitled to Medicare or that a dependent child has lost coverage under the Plan, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and information and forms you need to elect COBRA. To receive COBRA Continuation Coverage, you must elect it by returning a completed COBRA election form to the Fund Office within 60 days after receipt of the notice of your right to elect COBRA (or within 60 days after the date you would lose coverage, if later).

If you make this election and pay the required premium within the required deadlines, COBRA coverage will become effective on the day after coverage under the Plan would otherwise end. If you do not elect COBRA, your coverage under the Plan will end in accordance with the provisions listed under "When Coverage Ends," page 8.

Extension of 18-month COBRA coverage period for disability. If, during an 18-month COBRA coverage period, the Social Security Administration determines that you (or a member of your family who is eligible for COBRA coverage) were disabled at some time before the 60th day of COBRA coverage, the disabled person and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA coverage, for a maximum of 29 months. You must notify the Fund Office of the determination of your disability in writing and provide proof of your Social Security disability award within 60 days of the date of that determination and before the end of the 18-month period of COBRA coverage. If the 18-month period of COBRA coverage is extended because of Social Security disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month, 30 days after Social Security has determined that you and/or your eligible dependent(s) are no longer disabled;
- The end of the 29 months of COBRA coverage;
- The date the disabled person becomes entitled to Medicare.

You must notify the Fund Office in writing within 30 days of a final Social Security determination that you are no longer disabled.

Extension of 18-month COBRA coverage period for your spouse or dependent children due to a Second Qualifying Event. If your spouse or dependent children have COBRA continuation coverage because of your termination of employment or reduction in hours, they can get up to an extra 18 months of COBRA coverage if they have a second Qualifying Event (that is, they can get up to a total of 36 months of COBRA coverage). This extended COBRA coverage is available to your spouse and

dependent children if the second Qualifying Event is your death, divorce or legal separation. The extension is also available to a dependent child whose second Qualifying Event occurs when he or she stops being eligible under the Plan as a dependent child.

To elect extended COBRA coverage in all of these cases, you or any Qualified Beneficiary must notify the Fund Office in writing of the second Qualifying Event within 60 days after the second Qualifying Event (or the date that benefits would end under the Plan as a result of the first Qualifying Event, if later). If you do not notify the Fund Office in writing within the 60-day period, you will lose your right to elect additional COBRA continuation coverage.

Other Coverage Options Besides COBRA Continuation Coverage

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

Adding a dependent or spouse after COBRA coverage begins. If a child is born to you (the participant) or placed for adoption with you while you are covered by COBRA, you can add the child to your coverage as a Qualified Beneficiary with independent COBRA rights. In addition, each Qualified Beneficiary covered by COBRA has the same special enrollment rights and may add dependents in the same manner as an active employee, but such dependents are not Qualified Beneficiaries. For example, if you get married while you are covered by COBRA, you can add your new spouse to your COBRA coverage. However, your new spouse will not be a Qualified Beneficiary.

Cost of coverage. As provided by law, you and/or your enrolled dependents must pay the full cost of coverage plus 2% for administrative expenses for the full 18- or 36-month period. For a disabled person who extends coverage for more than 18 months, the cost for months 19 through 29 is 150% of the Fund's cost for the coverage. When two or more family members elect COBRA coverage, the family coverage cost under the Plan will apply. Since the cost to the Fund may change during the period of your continuation coverage, the amount charged to you may also change annually during this period.

Time for payment. You must send the initial payment for COBRA coverage to the Fund Office within 45 days of the date you first notify the Fund Office that you choose COBRA coverage (a U.S. Post Office postmark will serve as proof of the date you sent your payment). You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end).

After your initial payment, all payments are due on the first of the month. You have a 30-day grace period from the due date to pay your premium. If you fail to pay by the end of the grace period, your coverage will end as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, you must send your payment on or before the last day of the grace period (again, a U.S. Post Office postmark will serve as proof). Please note that if your check is returned unpaid from the bank for any reason, that may prevent your COBRA premiums from being paid on time and may result in cancellation of coverage, provided the amount due is not significantly less than the amount required for the coverage.

When COBRA Continuation Coverage ends. COBRA Continuation Coverage ends automatically on the last day of the month in which the earliest of the following dates falls:

- the date the maximum coverage period ends;
- the last day of the period for which the person covered under COBRA made a required premium

payment on time;

- the date after the election of COBRA that the person covered under COBRA first becomes covered under another group medical plan;
- the date after the election of COBRA that the person covered under COBRA first becomes entitled to Medicare;
- the first of the month that begins more than 30 days after the date the person whose disability caused the extension of coverage to 29 months is no longer disabled (based on a final determination from the Social Security Administration); or
- the date the Plan is terminated and the Fund provides no other medical coverage.

If continuation coverage ends before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following their determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

COBRA Continuation Coverage cannot under any circumstances extend beyond 36 months from the date of the Qualifying Event that originally made you or a dependent eligible to elect COBRA.

Once COBRA Continuation Coverage ends for any reason, it cannot be reinstated.

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

To protect your family's rights to COBRA coverage, keep the Fund Office informed of any changes of address for you and your family members.

If Your Employment or Coverage Ends: Converting Your Insured Coverage to Individual Coverage

Life insurance. After your group life insurance under the Plan ends, you may convert it to an individual life insurance policy, as long as you apply for converted coverage within 31 days after your employment ends. You may convert your group coverage to any type of individual policy (except term or disability insurance) being underwritten at that time by the life insurance carrier. Your converted policy may, if you choose, be proceeded by term insurance for not more than one year. The amount converted to an individual policy cannot be more than the group coverage you had under the Plan.

Your individual policy will not become effective until 31 days after your Plan coverage ends. Group life insurance protection continues in force, however, during this 31-day period, whether or not you exercise the conversion option. Your converted coverage will continue for as long as you make the required premium payments. Evidence of good health is not required to convert your coverage to an individual policy.

Contact Aetna for more information about converting coverage.

You cannot convert medical, prescription drug, dental, optical, short-term disability or accidental death and dismemberment benefits to individual coverage.

YOUR HEALTH BENEFITS

Your hospital and medical benefits are administered by Aetna and a summary of those benefits begins below. Your medical and health benefits provide coverage for the diagnosis and treatment of non-occupational illnesses and injuries, as well as for certain preventive care services.

Additional Option for Retirees: If you are retiring, or already retired and you qualify for retiree coverage, you have the option to choose the HIP HMO option. Keep in mind, however, that with this option, you must choose a primary care physician (PCP) and all care must be coordinated through your PCP. The HIP HMO does not cover any non-emergency services that you receive out-of-network or that are not coordinated by your PCP.

And—a word about Medicare: The HIP/VIP Medicare program is available to retired members living in New York, New Jersey and Florida. You must be age 65 or older and enrolled in Medicare Part A (hospital) and Part B (medical) and continue to receive your care through HIP medical centers and providers.

Contact the Fund Office for more information on this option for retirees.

Newborns' and Mothers' Health Protection Act of 1996

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the doctor), after consultation with the mother, discharges the mother or newborn earlier. Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a doctor or other health care provider obtain authorization for prescribing a length of stay after childbirth of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 Notice

The Women's Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to a mastectomy must provide coverage for:

- 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 physical complications associated with all stages of mastectomy, including lymphedemas.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to applicable copays, referral requirements, annual deductibles and coinsurance provisions, depending on the medical plan option you elect. If you have any questions, please contact the Fund Office.

Choice of Provider

The Plan does not require but does allow the designation of a primary care provider and you have the right to designate any primary care provider who participates in the Aetna network and who is available to accept you or your family members. You may designate a pediatrician as the primary care provider for your child. In addition, you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers, pediatricians or obstetrics/gynecology, contact Aetna at the number on your ID card.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Aetna network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna.

Provider Non-Discrimination

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

How this Plan Works

Covered Benefits, Exclusions and General Requirements

Covered Benefits and Exclusions. Your Plan provides covered benefits for a lot of – but not all – health care services. These are called Eligible Health Services and are the benefits for which the Plan has the obligation to pay. Doctor and hospital services are the foundation for many other services. You will probably find the preventive care, emergency services and urgent condition coverage especially important. Keep in mind that the Plan will not always cover the services you want; sometimes it does not cover health care services your doctor will want you to have.

This Plan provides In-network and Out-of-Network coverage for Medical and Vision benefits as described in the Schedule of Benefits and detailed in this section. Generally the Plan you will share the expense of your eligible health services when you meet the general requirements for paying. The amount that you are required to pay is referred to as your cost-sharing and will differ depending on what type of provider you use (e.g., in-network vs. out-of-network or facility vs. physician). Your cost-sharing is outlined in the Schedule of Benefits.

It is important to remember that the Plan does not pay for benefits that are not covered under the terms of the plan which are considered exclusions. The services and supplies that are excluded under this Plan are described more in greater detail at the end of this section. The health care services and supplies which are covered under the Plan are described in Eligible Health Services section which follows the Schedule of Benefits. In general, Eligible Health Services are health care services that meet these three requirements:

- They are listed in the Eligible Health Services in this document.
- They are not excluded as described in the Exclusions Section.
- They are not beyond any limits in the Schedule of Benefits.

Some of those health care services and supplies have specific exclusions. For example, physician care is an eligible health service, but physician care for cosmetic surgery is never covered. This is an example of an exclusion.

In-Network and Out-of-Network Providers

In-Network Coverage

You will pay less cost share when you use a network provider. Aetna's network of doctors, hospitals and other health care providers are there to give you the care you need. You can find network providers and see important information about them most easily on our online provider directory. Just log into your Aetna Member Portal secure member website at www.aetna.com.

Out-of-Network Coverage

In addition to benefits for In-Network providers, the Plan also provides coverage when you want to get your care from providers who are not part of the Aetna network. This is considered Out-of-Network or other health care coverage.

When you use an Out-of-Network Provider, you will have to pay for services at the time that they are provided and will pay a higher cost share. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible health services that you paid directly to a provider. It is your responsibility to start the precertification process with providers.

What the Plan Pays and What You Pay

When you get eligible health services, the Plan and you share the expense up to any maximum out-of-pocket limit. The *Schedule of Benefits* lists how much your plan pays and how much you pay for each type of health care service. Your cost-sharing share includes "deductibles" "copayment" and/or 'coinsurance" as described below. Once you reach your annual maximum out-of-pocket limit, the Plan will begin to pay the entire amount. When the term "expense" in used in this booklet, as a general rule it means the negotiated charge for a network provider, and the recognized charge for an out-of-network provider. See the *Glossary* section for what these terms mean.

You pay the entire expense for an eligible health service:

- When you get a health care service or supply that is not medically necessary.
- When your plan requires precertification, your physician requested it, we refused it, and you get an eligible health service without precertification.
- You will also be responsible for the entire expense of cancelled or missed appointments.

In all these cases, the provider may require you to pay the entire charge. And any amount you pay will

not count towards your deductible or towards your maximum out-of-pocket limit. See the *Medical necessity, referral and precertification requirements* section for details.

Neither you nor the Plan are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the negotiated charge

How your deductible works

Your deductible is the amount you need to pay, after paying your copayment or payment percentage, for eligible health services per Calendar Year as listed in the schedule of benefits. Your copayment or payment percentage does not count toward your deductible.

How your copayment/ payment percentage works

Your copayment/payment percentage is the amount you pay for eligible health services after you have paid your deductible. Your schedule of benefits shows you which copayments/payment percentage you need to pay for specific eligible health services.

Important Note

See the schedule of benefits for any copayments/ payment percentage, maximum out-of-pocket limit and maximum age, visits, days, hours, admissions that may apply.

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Deductible Per calendar year	Individual: None Family: None	Individual: $250 Family: $500
• All covered expenses accumulate separately toward the preferred or non-preferred Deductible. • Unless otherwise indicated, the Deductible must be met prior to benefits being payable. • Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. • In-network deductible is waived for preventive care and wellness services		
Member Coinsurance	No charge	10%
Payment Limit Per calendar year	Individual: $1,000 Family: $2,000	Individual: $2,000 Family: $2,000
• **All covered expenses accumulate toward the preferred or non-preferred Payment Limit. Certain member cost-sharing elements may not apply toward the Payment Limit.** • Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise indicated	
Payment for Non-Preferred*	Not applicable	Professional: Prevailing charges (up to 225% of the Medicare fee schedule) Facility: Prevailing charges (up to 200% of the Medicare fee schedule)
Referral Requirement	None	None
PREVENTIVE CARE		
Routine Adult Physical Exams/Immunizations	Covered 100%, no deductible applies	10%; deductible waived
1 exam every 12 months ages 19 and over		
Routine Well Child Exams/Immunizations	Covered 100%, no deductible applies	100%; deductible waived
7 exams in the first 12 months of life, 3 exams per year from 12 months to 36 months, and 1 exam per year to age 19.		

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Routine Gynecological Care Exams Covers 2 exams annually, including related test and related lab fees	Covered 100%, no deductible applies	10%; deductible waived
Routine Mammograms	Covered 100%, no deductible applies	10%; deductible waived
Women's Health	Covered 100%, no deductible applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered: after deductible
Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam/ Prostate-specific Antigen Test 1 DRE and PSA test per year, no age limits	Covered 100%, no deductible applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Colorectal Cancer Screening For all members age 45 and over	Covered 100% , no deductible applies	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.
Routine Hearing Exams	Covered 100%, no deductible applies	10%, deductible waived
1 routine exam every 12 months		
PHYSICIAN SERVICES		
Office Visits to Non-Specialist (non-surgical)	$15 office visit copay, no deductible applies	10%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits (non-surgical)	$25 office visit copay, no deductible applies	10%; after deductible
E-visit to non-Specialist	$15 copay	Not Covered

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
An e-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet e-visit service vendor.		
E-visit to Specialist	$25 copay	Not Covered
An e-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet e-visit service vendor.		
Walk-in Clinics	$15 office visit copay, no deductible applies	10%; after deductible
Walk-in Clinics are network, free-standing heath care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Office Visits for Surgery	Covered 100%	10%; after deductible
Pre-Natal Maternity	Covered 100%	10%; after deductible
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	10%; after deductible
Allergy Injections	Covered 100%	10%; after deductible
DIAGNOSTIC PROCEDURES		
Diagnostic Laboratory and X-ray	Covered 100%, no deductible applies	10%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost-sharing.		
EMERGENCY MEDICAL CARE		
Emergency Room	$150 copayment, Deductible does not apply	Paid the same as in-network coverage
Urgent Care Provider (benefit availability may vary by location)	$25 copay, no deductible applies	10%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Non-Emergency care in an Emergency Room	Not Covered	Not Covered

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Ambulance	Covered 100%, no deductible applies	100%; no deductible applies
HOSPITAL CARE		
Inpatient Coverage	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery Free Standing Facility	Covered 100%	10%, after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES		
Inpatient Hospital Expenses	Covered 100%, no deductible applies	10%, after deductible
Outpatient Office Visits	$15 copay	10%; after deductible
Outpatient Other (Outpatient Hospital Expenses/Outpatient Free Standing Facility)	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICE		
Inpatient	Covered 100%, no deductible applies	10%; after deductible

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Outpatient Office Visits	$15 copay	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES		
Convalescent Facility Limited to 120 days per calendar year.	Covered 100%	10%; after deductible
The member cost-sharing applies to all covered benefits incurring during a member's inpatient stay.		
Home Heath Care Limited to 200 visits per year.	Covered 100%, no deductible applies	10%; deductible waived
Hospice Care – Inpatient	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care – Outpatient	Covered 100%, no deductible applies	10%; after deductible
The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing – Outpatient (Limited to 70 eight-hour shifts per calendar year.)	Covered 100%, no deductible applies	10%; deductible waived
Autism Spectrum PT/OT/ST	Covered 100%, no deductible applies	10%; after deductible
Covered same as any other Short Term Rehabilitation expense. No age or visit limit restrictions.		
Autism Spectrum Behavior Therapy	$25 copay	10%; after deductible
Covered same as any other Outpatient Mental Health benefit.		
Autism Spectrum Applied Behavior Analysis	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Covered same as any other expense with no age restrictions. Limited to 680 hours of treatment per calendar year.		

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Outpatient Short-Term Rehabilitation	Covered 100%, no deductible applies	10%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	$25 office visit copay, no deductible applies	10%; after deductible
Durable Medical Equipment	Covered 100%, no deductible applies	10%; after deductible
Diabetic Supplies (if not covered under Pharmacy benefit)	Covered same as non-specialist office visit cost sharing	10%; after deductible
Contraceptive Drugs and Devices Not Obtainable at a Pharmacy	Covered 100%	10% after deductible (payable as any other covered expense)
Generic FDA-approved Women's Contraceptives	Covered 100%	Not Covered
Gene-based, cellular and other innovative therapies (GCIT)	Covered at 100%	Not Covered
GCIT benefits must be from Aetna GCIT-designated providers and facilities. GCIT services and supplies are covered based on type of service and where it is received. Out of network GCIT benefits are not covered, including providers who are outside Aetna's network and providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/providers. For up-to-date information on GCIT coverage please contact the Fund Office or Aetna member services.		
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only	10% after deductible, Non-Preferred coverage if provided at a Non-IOE facility
Bariatric	Covered 100%	10% after deductible
The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING		
Infertility Treatment	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.	Member cost-sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		

PLAN FEATURE	PREFERRED CARE (IN-NETWORK)	NON-PREFERRED CARE (OUT-OF-NETWORK)
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of service where rendered	Applicable cost sharing based on the type of service performed and place of service where rendered; after deductible
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Tubal Ligation	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

Medical Necessity and Precertification Requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible health services. See the *Eligible Health Services Under Your Plan* and *Exclusions* sections plus the schedule of benefits. Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is Medically Necessary. That definition explains what Aetna's medical directors or their physician designees consider when determining whether an eligible health service is medically necessary.
- You or your provider precertifies the eligible health service when required.

Precertification

You need pre-approval from Aetna for some eligible health services. Pre-approval is also called precertification.

In-network: Your physician is responsible for obtaining any necessary precertification before you get the care. If your physician doesn't get a required precertification, Aetna won't pay the provider who gives you the care. You won't have to pay either if your physician fails to ask Aetna for precertification. If your physician requests precertification and Aetna refuses it, you can still get the care but the Plan won't pay for it. You will find details on requirements in the *What The Plan Pays And What You Pay - Important exceptions – when you pay all* section.

Out-of-network: When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. Refer to the Schedule of Benefits for this information. The list of services and supplies requiring precertification appears later in this section. Also, for any precertification benefit reduction that is applied see the schedule of benefits *Precertification benefit reduction* section.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	**You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.**
For an urgent admission:	**You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.**
For outpatient non-emergency medical services requiring precertification:	**You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.**

- Aetna will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

- When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered benefits, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision. See the *Claim decisions and appeals procedures* section.

If you do not obtain the required precertification your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification benefit reduction* section.

- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network deductibles; or
- Maximum out-of-pocket limits.

Precertification is required for the following types of services and supplies:

- Inpatient services and supplies
- Stays in a hospital

- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse
- Bariatric surgery (obesity)
- Comprehensive infertility services
- Cosmetic and reconstructive surgery

Eligible Health Services Under Your Plan

The Plan covers many kinds of health care services and supplies, such as physician care and hospital stays. But sometimes those services are not covered at all or are covered only up to a limit. For example,

- Physician care is generally covered but physician care for cosmetic surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a covered benefit only up to a set number of visits a year. This is a limitation.

You can find out about these Exclusions in the *Exclusions* section, and about the limitations in the *Schedule of Benefits.*

Preventive care and wellness

- You will see references to the following recommendations and guidelines in this section:
  - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - United States Preventive Services Task Force
  - Health Resources and Services Administration
  - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

- Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to eligible health services for diagnostic testing.
- Gender-Specific Preventive Care Benefits include eligible health services regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on

your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your physician, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital checkup

Preventive care immunizations

Eligible health services include immunizations provided by your physician, PCP or other health professional for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The Plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well Woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. The Plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

Eligible health services include screening and counseling by your health professional for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

Obesity and/or healthy diet counseling. Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of alcohol and/or drugs. Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Use of tobacco products. Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;
- Tobacco cessation prescription and over-the-counter drugs
  - Eligible health services include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. See the Prescription Drug section for details on medications covered under this Plan.

Tobacco product means a substance containing tobacco or nicotine such as cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco

Sexually transmitted infection counseling. Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic risk counseling for breast and ovarian cancer. Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your physician's, PCP's, OB's, GYN's, or OB/GYN's office.

Important note: You should review the benefit under *Eligible Health Services Under the Plan- Maternity and Related Newborn Care* and the *Exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services. Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. The Plan will cover this counseling only when you get it from a certified lactation support provider.

Breast feeding durable medical equipment. Eligible health services include renting or buying durable medical equipment you need to pump and store breast milk as follows:

Breast pump. Eligible health services include:

- Renting a hospital grade electric pump while your newborn child is confined in a hospital.

- The buying of:
  - An electric breast pump (non-hospital grade). Your plan will cover this cost once every 12 months, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous twelve-month period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories. Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. Including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives. Eligible health services include family planning services such as:

Counseling services. Eligible health services include counseling services provided by a physician, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices. Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a physician during an office visit.

Voluntary sterilization. Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note: See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services. Eligible health services include services by your physician to treat an illness or injury. You can get those services at the physician's office, in your home or a hospital or from any other inpatient or outpatient facility.

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services. Eligible health services include the services of:

- The surgeon who performs your surgery
- Your surgeon who you visit before and after the surgery
- Another surgeon who you go to for a second opinion before the surgery

Important note: Some surgeries can be done safely in a physician's office. For those surgeries, your plan will pay only for physician services and not for a separate fee for facilities.

Alternatives to physician office visits

Walk-in clinic. Eligible health services include health care services provided in walk-in clinics for:

- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care. Eligible health services include inpatient and outpatient hospital care. The types of hospital care services that are eligible for coverage include:

- Room and board charges up to the hospital's semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of physicians employed by the hospital
- Operating and recovery rooms
- Intensive or special care units of a hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a hospital.

Alternatives to hospital stays

Outpatient surgery and physician surgical services. Eligible health services include services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital's outpatient department.

Important note: Some surgeries can be done safely in a physician's office. For those surgeries, your plan will pay only for physician services and not for a separate fee for facilities.

Home health care and skilled behavioral health services in the home. Eligible health services include home health care services and skilled behavioral health services provided by a home health agency in the home, but only when all of the following criteria are met:

HOME HEALTH CARE SERVICES	SKILLED BEHAVIORAL HEALTH SERVICES IN THE HOME
You are homebound.	**You are homebound.**
Your physician orders them.	**Your physician orders them.**
The services take the place of your needing to stay in a hospital or a skilled nursing facility, or needing to receive the same services outside your home.	**The services take the place of your needing to stay in a hospital or a residential treatment facility, or needing to receive the same services outside your home.**
The services are part of a home health care plan.	**The services are part of an active treatment plan of care.**
The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.	**The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.**
If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.	
Home health aide services are provided under the supervision of a registered nurse.	
Medical social services are provided by or supervised by a physician or social worker.	

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits. Home health care services do not include custodial care or applied behavior analysis.

Hospice care. Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis

- Services by a hospice care agency or hospice care provided in a hospital
- Bereavement counseling
- Respite care

Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling
  - Dietary counseling

Outpatient skilled nursing care. Eligible health services include services provided by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care. This is care by a visiting R.N., or L.P.N. to perform specific skilled nursing tasks.

The Plan also covers private duty nursing provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care and visiting nursing care is not adequate.

Skilled nursing facility. Eligible health services include inpatient skilled nursing facility care. The types of skilled nursing facility care services that are eligible for coverage include:

- Room and board, up to the semi-private room rate
- Services and supplies that are provided during your stay in a skilled nursing facility

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an emergency medical condition or an urgent condition. As always, you can get emergency care from network providers. However, you can also get emergency care from out-of-network providers. Coverage for emergency services and urgent care from out-of-network providers ends when Aetna and the attending physician determine that you are medically able to travel or to be transported to a network provider if you need more care. As it applies to In-Network coverage, you are covered for follow-up care only when your physician or PCP provides or coordinates it. If you use an Out-of-Network Provider to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency. When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician or PCP but only if a delay will not harm your health.

Non-emergency condition. If you go to an emergency room for what is not an emergency

medical condition, the Plan may not cover your expenses. See the schedule of benefits and the *exclusion- Emergency services and urgent care and Precertification benefit reduction* sections for specific plan details.

Urgent condition. If you need care for an urgent condition, you should first seek care through your physician or PCP. If your physician or PCP is not reasonably available to provide services, you may access urgent care from an urgent care facility.

Non-urgent care. If you go to an urgent care facility for what is not an urgent condition, the Plan may not cover your expenses. See the *exception –Emergency services and urgent care and Precertification benefit reduction* sections and the schedule of benefits for specific plan details.

No Surprises Act Services

The Fund follows the requirements set forth by the No Surprises Act ("NSA"). The NSA sets forth the following requirements on how certain benefits must be covered:

I. Emergency Services

Emergency Services will be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;
2. Without regard to whether the health care Provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;
3. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;
4. Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;
5. By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.

As a result of the No Surprises Act, you will no longer be responsible for balance billing associated with the use of Out-of-Network Emergency Services.

II. Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility will be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that

would apply if the items or services had been furnished by an In-Network Provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Insurance Fund in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Insurance Fund, the estimated charges for your treatment and any advance limitations that the Insurance Fund may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

III. Out-of-Network Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network Provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Please note, the Fund only covers air ambulance services if they are deemed medically necessary.

IV. Continuity of Care

In the event a Participant is a Continuing Care Patient, as defined below, with respect to such provider or facility and the contractual relationship with the provider or facility expires, is not renewed, or terminated for any reason other than the provider's or facility's inability to meet applicable quality standards or for fraud, the Fund shall:

1. notify each enrolled individual who is a Continuing Care Patient with respect to a provider or facility at the time of a termination affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility;
2. provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and
3. permit the patient to elect to continue to have benefits provided under the Plan under the same terms and conditions as would have applied and with respect to such items and services as would have been covered had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a Continuing Care Patient during the period beginning on the date on which the notice of termination is provided and ending on the earlier of (a) the 90-day period beginning on such date; or (b) the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

V. Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by calling the phone number on your Aetna ID card. The network provider directory contains the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which the Plan has a contractual relationship for furnishing items and services.

Aetna updates its directories at least every ninety (90) days and will respond to an inquiry about the network status of a provider or facility within one (1) business day.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Plan, the Plan will apply In-Network cost-sharing to your claim, even if the provider was an Out-of-Network provider at the time the service was rendered. However, it is your responsibility to confirm that the Provider or facility that you have selected is In-Network at the time you receive services.

VI. External Review Process of Certain Coverage Determinations

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

VII. Complaint Process

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

Routine Patient Costs in Connection with Approved Clinical Trials

If you are deemed eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

- Not deny you participation in the trial;
- Not deny, limit, or impose additional conditions on the Plan's coverage of in-network routine patient costs for items, services, or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- Will not discriminate against you because of your participation in the trial.

The Plan will deem you eligible to participate in the trial if:

- Your health care provider is a participating provider in this Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
- You provide medical and scientific information establishing that your participation would be medically appropriate, or Aetna determines based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

Routine patient costs do not include the following:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Specific conditions and services

Autism Spectrum Disorder. Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of Autism Spectrum Disorder. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.

The Plan will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Birthing center. Eligible health services include prenatal and postpartum care and obstetrical services from your provider. After your child is born, eligible health services include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery
- A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Family planning services – other. Eligible health services include certain family planning services provided by your physician such as Voluntary sterilization for males.

Gene-based, cellular and other innovative therapies (GCIT). Eligible health services include services that are gene-based and cellular and innovative therapeutics. These services have a basis in genetic/molecular medicine and are not covered under Aetna's Institutes of Excellence programs.

GCIT covered services include:

- Cellular immunotherapies
- Genetically modified oncolytic viral therapy
- Other types of cells and tissue from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use.
- Products derived from gene editing technologies, including CRISPR-Cas9
- Oligonucleotide-based therapies

Please note, you must receive GCIT covered services from Aetna GCIT-designated providers and facilities. Out of network GCIT benefits are not covered, including providers who are outside Aetna's network and providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/providers.

If there are no GCIT-designated facilities or providers assigned in your network, contact Aetna member services.

Maternity and related newborn care. Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, eligible health services include:

- 48 hours of inpatient care in a hospital after a vaginal delivery

- 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a provider.

Mental health treatment. Eligible health services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:

- Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician. Intensive Outpatient Program provided in a facility or program for mental health treatment provided under the direction of a physician.
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor.
  - Other outpatient mental health treatment such as:
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Substance use disorder injectables

Eligible health services also include skilled behavioral health services provided in the home, but only when all of the following criteria are met:

- You are homebound.
- Your physician orders them.
- The services take the place of a stay in a hospital or a residential treatment facility, or needing to receive the same services outside your home.
- The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.

Substance related disorders treatment. Eligible health services include the treatment of substance abuse provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:

- Inpatient room and board at the semi-private room rate and other services and supplies that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Treatment of substance abuse in a general medical hospital is only covered if you

are admitted to the hospital's separate substance abuse section or unit, unless you are admitted for the treatment of medical complications of substance abuse.

- As used here, "medical complications" include, but are not limited to, detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Partial hospitalization treatment provided in a facility or program for treatment of substance abuse provided under the direction of a physician.
  - Intensive Outpatient Program provided in a facility or program for treatment of substance abuse provided under the direction of a physician.
  - Ambulatory detoxifications which are outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications.
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor.
  - Other outpatient substance abuse treatment such as:
    - Outpatient monitoring of injectable therapy

Obesity surgery. Eligible health services include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are morbidly obese, for the purpose of losing weight.

Obesity is typically diagnosed based on your body mass index (BMI). To determine whether you qualify for obesity surgery, your doctor will consider your BMI and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a BMI less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a network provider for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient prescription drug benefits included under the Outpatient prescription drugs section

Health care services include one obesity surgical procedure. However, eligible health services also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our network facilities that perform obesity surgeries.

Oral and maxillofacial treatment (mouth, jaws and teeth). Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dentist and hospital:

- Non-surgical treatment of infections or diseases.

  - Surgery needed to:
    - Treat a fracture, dislocation, or wound.
    - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
    - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
    - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after an injury.

Reconstructive surgery and supplies. Eligible health services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes surgery on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the surgery is to improve function.
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

Transplant services. Eligible health services include organ transplant services provided by a physician and hospital. Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities. The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- A Non-IOE facility

The National Medical Excellence Program® will coordinate:

- All solid organ and bone marrow transplants
- Other specialized care you need.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services. Eligible health services include complex imaging services by a provider, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500 Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services. Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy. Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

Outpatient infusion therapy. Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in his/her office
- A home care provider in your home

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions. When Infusion therapy services and supplies are provided in your home, they will

not count toward any applicable home health care maximums.

Specialty prescription drugs. Eligible health services include specialty prescription drugs when they are:

- Purchased by your provider, and
- Injected or infused by your provider in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a hospital
  - A physician in his/her office
  - A home care provider in your home

Please note, not all prescription drugs are covered through your medical benefits. Aetna does not provide full prescription drug benefits under this Plan. For full prescription benefits, please call the Fund Office or OptumRx, your pharmacy benefits manager.

Outpatient radiation therapy. Eligible health services include the following radiology services provided by a health professional:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Short-term cardiac and pulmonary rehabilitation services. Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation. Eligible health services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation. Eligible health services include pulmonary rehabilitation services as part your inpatient hospital stay if it is part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a hospital, skilled nursing facility, or physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.

Short-term rehabilitation services. Short-term rehabilitation services help you restore or develop skills and functioning for daily living. Eligible health services include short-term rehabilitation services your physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility

- A home health care agency
- A physician

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy. Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure, or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.
    - Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services. Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). Eligible health services include habilitation therapy services your physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A home health care agency
- A physician

Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient physical, occupational, and speech therapy. Eligible health services include:

- Physical therapy, if it is expected to develop any impaired function.

- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your ability to perform the activities of daily living.
- Speech therapy is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development (Speech function is the ability to express thoughts, speak words and form sentences).

Other services

Acupuncture. Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your physician, up to 12 visits per year.

Ambulance service. Eligible health services include transport by professional ground ambulance services:

- To the first hospital to provide emergency services.
- From one hospital to another hospital if the first hospital cannot provide the emergency services you need.
- From hospital to your home or to another facility if an ambulance is the only safe way to transport you.
- From your home to a hospital if an ambulance is the only safe way to transport you. Transport is limited to 100 miles.

The Plan also covers transportation to a hospital by professional air or water ambulance when:

- Professional ground ambulance transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one hospital to another and
  - The first hospital cannot provide the emergency services you need, and
  - The two conditions above are met.

Durable medical equipment (DME). Eligible health services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of DME for the same or similar purpose.
- Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if

it would be cheaper than repairing it or renting a similar item.

Hearing exams. Eligible health services include hearing care that includes hearing exams.

Nutritional supplements. Eligible health services include formula and low protein modified food products ordered by a physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Prosthetic devices. Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Spinal manipulation. Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your provider establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Exclusions: What's Not Covered

The Plan covers many health care services and supplies. Following is a list of services and supplies that are NOT covered or are excluded by the Plan. This list is not exhaustive, for a full list of excluded services and supplies, contact Aetna.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes. Examples are:

- The provision of blood to the hospital, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.
- For autologous blood donations, only administration and processing expenses and certain expenses as described in Aetna's certificate are covered.

Cosmetic services and plastic surgery. Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except if and where described in Aetna's certificate.

Counseling. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies. Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care. Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care

- Not covered when services are normally covered under a dental plan, except as covered as medically necessary in Aetna's certificate

Educational services. Examples of those services are:

• Any service or supply for education, training or retraining services or testing. This includes:

– Special education

– Remedial education

– Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)

– Job training

– Job hardening programs

• Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations. Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy coverage or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational. Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the Eligible health services under your plan – Other services section.

Facility charges. For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care. Services and supplies for:

- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies unless covered by the Plan
- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Growth/Height care. Services and supplies for:

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Jaw joint disorder. Services and supplies for:

- Non-surgical and surgical medical, dental, diagnostic or therapeutic services related to jaw joint disorder

Maintenance care. Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function.

Medical supplies – outpatient disposable. Any outpatient disposable supply or device.

Examples of these are:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer. Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Personal care, comfort or convenience items. Any service or supply primarily for your convenience and personal comfort or that of a third party.

Services provided by a family member. Services provided by a spouse, parent, child, step-child, brother, sister, in-law or any household member.

Services, supplies and drugs received outside of the United States. Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sex change. Any treatment, drug, service or supply related to changing sex or sexual characteristics. Examples of these are:

- Surgical procedures to alter the appearance or function of the body
- Hormones and hormone therapy
- Prosthetic devices

Sexual dysfunction and enhancement. Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Treatment in a federal, state, or governmental entity. Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Therapies and tests. Services and supplies for:

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the Eligible health services under the Plan Preventive care and wellness benefits
- Hypnosis and other therapies
- Medications including nicotine patches and gum except as specifically provided under the Prescription Drug program. See the Prescription Drug section of this booklet for details.

Work related illness or injuries.

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Specific exclusions

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services. Services and supplies for:

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement.

Outpatient surgery and physician surgical services. Services and supplies:

- For any other physician who helps the operating physician

- For a stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section.)
- For a separate facility charge for surgery performed in a physician's office
- Of another physician for the administration of a local anesthetic

Behavioral Health Treatment. Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the Coverage and Preventive care section
- Pathological gambling, kleptomania, and pyromania

Home health care. Services and supplies:

- For infusion therapy
- Provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- For transportation
- Provided to a minor or dependent adult when a family member or caregiver is not present
- Which are not for Applied Behavior Analysis

Hospice care. Includes the following:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Emergency services and urgent care. Services and supplies for:

- Non-emergency care in a hospital emergency room facility

- Non-urgent care in an urgent care facility(at a non-hospital freestanding facility)

Maternity and related prenatal care. Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health treatment. See Behavioral Health treatment

Substance related disorders treatment. Except as provided in the Eligible health services under your plan – This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

Oral and maxillofacial treatment (mouth, jaws and teeth). Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Treatment of infertility

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm for ART services from males who are not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products

Short-term rehabilitation services (except as covered as Eligible health services under your plan)**.** Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Autism Spectrum Disorder
  - Down syndrome
  - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a home health care agency.
- Services provided by a physician, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Habilitation therapy services (except as covered as Eligible health services under your plan)**.** Physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Down syndrome
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a home health care agency.
- Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Other services Not Covered

Ambulance services. Fixed wing air ambulance from an out-of-network provider, unless deemed medically necessary

Clinical trial therapies (experimental or investigational). Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

Durable medical equipment (DME). Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Message devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements. Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered as Eligible health services under your plan

Prosthetic devices. Examples of these items are:

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

PRESCRIPTION DRUGS BENEFITS

Overview of Prescription Drug Coverage

The Prescription Drug Benefit is designed to help you pay for your prescription drug needs. Prescription drug benefits are administered by OptumRx whose phone number and address are listed on the Quick Reference Chart in the front of this document.

There are two different ways for you to obtain a prescription medication (which are described on in this section):

- From retail pharmacies using a prescription drug card; and
- By mail order.

Copayments and Annual Out-of-Pocket Maximum

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them. You will be required to pay a copayment when you receive a prescription. The copayment is a set dollar amount you pay for the prescription while the Plan pays the rest (or most of the rest) of the cost of that prescription. Copayments vary depending on whether you receive a generic, Preferred Brand Name Drug (formulary) or Non-Preferred Brand Name Drug (non- formulary) which are defined below. Once you reach the out-of-pocket limit for prescription drugs during the Plan year, the Plan will pay 100% of your prescription drugs for the remainder of the Calendar Year (December 31st). The amount of the out-of-pocket maximum is shown in the chart below.

- **Generic.** A generic drug is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety.
- **Preferred Brand Name Drug – Formulary Drugs.** A formulary is a list of preferred medications. The list has been put together by doctors and pharmacists and will be regularly updated and maintained by them. The list contains both brand name and generic drugs to treat all illnesses. In fact, many of the drugs you are already taking are included on the list. Drugs are added and taken off the formulary list from time to time. Therefore, the formulary list is subject to change. You should call OptumRx or visit their web site to check if a medication is preferred and information about the formulary. You may also request a complete list of drugs that are considered Preferred drugs by contacting OptumRx.
- **Non-Preferred Brand Name Drug - Non-Formulary Drugs.** A non-preferred or non-formulary drug is a medication that is not listed on the formulary.

Summary of Prescription Drug Benefit Copayments

Medication Type	Prescriptions from a Retail Pharmacy	Specialty Prescription Drugs	Prescription from a Mail Order Pharmacy
Generic Medications	$5	$5	$10
Preferred Brand Name Drugs	$15	$10	$30
Non-Preferred Brand Name Drugs	$25	$15	$50
ACA-Required Preventive Medication	$0	N/A	$0
	Note that maintenance-type medications can be filled up to a maximum of two times at a participating retail pharmacy, then they must be submitted through the mail order program described below.		
Supply of Medication	30-days per prescription or refill	30-days per prescription or refill	90-days per prescription or refill
Annual Out-of-Pocket Maximum:		Individual: $5,500 / Family: $11,000	

Covered Drugs

Plan covers a wide range of federal legend prescription drugs (those that bear the legend "Caution: Federal law prohibits dispensing without a prescription") that are written by licensed physicians acting within the scope of their licenses. The Plan does not cover over the counter drugs except for insulin and diabetic supplies (including insulin syringes/needles and diabetic test strips) and those preventive medications as required under the Affordable Care Act (ACA).

Mandatory Mail Order Requirement

Maintenance-type medications can be filled up to a maximum of two times at a participating retail pharmacy, then they must be submitted through the mail order program described in the *Mail Order Pharmacy Benefits* subsection on the following pages.

Preventive Medications

The Affordable Care Act (ACA) makes certain preventive medications available to you at no cost. The following generic preventive medications are covered 100%. Brand name drugs are payable only if a generic alternative is medically inappropriate. This list should be used as a guide. It cannot be considered a comprehensive listing of medications available or covered

without cost-sharing. You should contact OptumRx for the most up to date list. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider. This list is subject to change as ACA guidelines are updated or modified.

- Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with plan rules.
- All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 180-day treatment regimen when prescribed by a health care provider without prior authorization.
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with plan rules.
- Risk-reducing medications (such as Tamoxifene or Raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
- All FDA-approved generic contraceptive methods for women of reproductive capacity including generic barrier methods, hormonal methods, and implanted devices hormonal methods, and contraceptive devices. The plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider.
- Folic Acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Bowel Preps in connection with a screening colonoscopy.

For a full list of covered preventive benefits, see:

http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

https://www.healthcare.gov/what-are-my-preventive-care-benefits/

http://www.hrsa.gov/womensguidelines/

Retail Pharmacy Benefits

Participating Pharmacy. When you need to fill an occasional prescription, such as for antibiotics for an infection, using a retail pharmacy is most convenient. By filing prescriptions at participating pharmacy, you minimize your out-of-pocket costs. Most nationwide retail drugstore chains as well as thousands of independent retail pharmacies participate in the OptumRx Network. To find out if your pharmacy participates in the program, call OptumRx.

You can also get 90-day supplies of maintenance medications through Optum Home Delivery, or get 90-day supplies of maintenance medications at more than 9,000 CVS Pharmacy locations. At the CVS locations, members will pay the home delivery cost share for a 90-day supply, which is often lower than the cost share for three 30-day supplies.

You will receive an OptumRx prescription drug identification card when you first become eligible for health benefits. With the prescription card, you can obtain any covered drug at the discounted in-network price by paying the applicable copayment. Your prescription drug card allows you to purchase up to a 30-day supply at a time. If you try to fill your prescription at a participating drugstore pharmacy without your ID card, your purchase may be delayed until your coverage is verified.

Out-of-Network/Non-Participating Pharmacies. If you use a non-participating pharmacy, you will have to pay the full prescription cost and send the claim to OptumRx for direct reimbursement. Claim forms are available from the Fund Office. You must submit the claim within 90 days of the date of service or OptumRx will deny your claim. You will be responsible for any amounts above the OptumRx Allowed Amount for the drug. In addition, these expenses will not count toward the Out-of-Pocket Maximum.

Mail Order Pharmacy Benefits

Mail service offers a convenient and less expensive way to fill prescriptions for medications you take for an extended period. You can receive up to a 90-day supply plus refills of maintenance-type medications to treat chronic or long-term conditions (like arthritis, high blood pressure, or diabetes) when you use the mail order service through OptumRx Mail. For more than two 90-day supplies of medications, you must obtain another prescription from your doctor.

How You File Your First Mail Order Prescription. You are required to complete an Enrollment/Order Form for New Participants and the Patient Profile for you and your covered family members when you first access the mail order. This form is available from the Fund Office. **You will need to complete this Form only with your first order.**

Prescriptions will generally be prescribed electronically and send directly to OptumRx. However, if your provider gives you a prescription for a maintenance type drug, ask him to write a prescription for a 90-day supply, plus one, two or three refills. Next, write your member ID number and group number on the back of each original prescription and mail your prescriptions(s) with the completed form in the pre-addressed postage-paid envelope provided. Forms and envelopes can be obtained from OptumRx or the Fund Office. Your prescription

order will be delivered postage-paid directly to your home. If you have any questions or problems regarding your prescription order, or if you do not receive your medication within 14 days, contact OptumRx Mail at 800-881-1966. Allow a few extra days from the time you place an order with OptumRx Mail.

Filing Refills or New Prescriptions. For refills, complete the Prescription Order Form provided with your previous order and mail the order form to OptumRx Mail. Be sure to fill in your Member ID number, group number, prescription number, and credit card information, if applicable. The prescription label and the customer receipt will indicate the number of times you may have a prescription refilled.

For new prescriptions, simply complete the Prescription Order Form included with each order and mail the form and original prescription to OptumRx Mail in the preaddressed, postage-paid envelope with all the same information required for your first prescription, described above.

When Medical Information Changes. The Patient Profile is maintained on file to help prevent adverse reactions with other prescriptions you are receiving from OptumRx and OptumRx Mail. If any questions arise regarding potential drug interactions or other adverse reactions, the pharmacist will contact your doctor or you before dispensing the medication. If you have additional medical information or changes to report, please notify OptumRx Mail in writing so that they may update your Patient Profile.

Prior Authorization

If you or your eligible dependent's physician wants you to take any of the following medications, you will need to obtain prior authorization in order for it to be covered. Through this program, the Plan will cover these prescription medications under certain clinical protocols established by OptumRx. If approved, the medication will be considered for payment under the Plan.

Generally, you may present a prescription to be filled that requires prior authorization directly to a pharmacy. OptumRx will work with the pharmacists and your physician to verify whether the drug is covered under the Plan and can direct you to what to do if it is not. If you need to obtain Prior Authorization for any prescription or need to contact OptumRx, you may call them at 800-711-4555.

You must obtain prior authorization for the following:

You should call OptumRx to initiate the pre-authorization process. As this list of medications that require prior authorization changes from time to time, you should contact OptumRx to obtain the most up-to-date information. If you are denied pre-authorization, you have the right to appeal the denial. If you do not obtain pre-authorization, your prescription claim will be denied unless you obtain written authorization from your doctor explaining the medical necessity for the prescription drug.

Prescription Drug Exclusions and Limitations

No payment will be made under the Plan for charges incurred for:

- Non-FDA approved drugs or drugs approved by the FDA for other use.
- Over-the-counter drugs (except required preventative drugs under the ACA for which you present a prescription).
- Drugs and injectable insulin obtained without a doctor's prescription.
- Drugs for which no charge is made or for which you are not required to pay.
- Any drug or medication that, when taken or used in accordance with the directions of the prescribing doctor, provides more than a 34-day supply or more than 100 unit doses, whichever is greater (or more than 90 days for a mail-order drug), without the necessity for a refill.
- Drugs labeled "caution-limited by federal law to investigational use," or experimental drugs.
- Any charge for the administration of prescription legend drugs or injectable insulin.
- Refilling of a prescription in excess of the number of times specified by the doctor, or any refill dispensed after 90 days from the order of a doctor.
- Drugs dispensed by a hospital for resident bed patients or by a rest home or sanitarium.
- Yohimbine, Nystating powder, lutrepulse.
- Progesterone products.
- Alcohol swabs.
- Anorectic drugs (for weight loss).
- Cosmetic drugs.
- Dental products.
- Erectile dysfunction drugs except up to 6 oral pills per month.
- Fertility drugs.
- Fluoride preparations (except required preventative drugs under the ACA for which you present a prescription).
- Hair growth products.
- Immunization agents.
- Injectable drugs and vitamins, including migraine medications unless accompanied with a physician's letter citing that there is a medical necessity for the medication and that an adverse medical condition would result from taking the medication orally. Injectable chemotherapy is covered.
- Non-Diabetic needles and syringes.
- Nutritional supplements.
- Surgical supplies/medical devices.
- Vitamins (except children's vitamins with fluoride). Pre-natal vitamins are covered.
- Drugs, medicines or devices for:

  - drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance including but not limited to androgen products, anabolic steroids;
  - non-prescription contraceptives which are not prescribed by a physician, and condoms;
  - fertility products or agents;
  - dental products such as fluoride preparations and products for periodontal disease;
  - hair removal or hair growth products (e.g., Propecia, Rogaine, Minoxidil, Vaniqa);
  - erectile dysfunction;
  - cosmetic products such as Restylane and Renova and/or
  - weight management products (e.g., Xenical), except those weight management prescription drugs that have a dual use for treatment of individuals with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or required preventative drugs under the ACA.
- Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, Ambulatory Surgical Facility/Center, or other health care facility.
- Any prescription drug or medicine for which there is a generic equivalent available in non-prescription form.
- Self-help devices such as a scale for weight or body fat measurement, pill crusher, pill splitter, magnifying glass/device, etc. except that a home personal use blood pressure measuring device is payable as Durable Medical Equipment when determined to be Medically Necessary by the Plan Administrator or its authorized designee (including a Claims Administrator).

OptumRx will review this list from time to time in light of new drugs approved by the FDA and other considerations and will revise the list of covered and non-covered drugs based on criteria established by OptumRx. Please contact OptumRx for the most up-to-date information on drugs not covered by the Plan.

Specialty Drugs

Specialty drugs are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis, hepatitis or growth hormone. These drugs may need precertification, often require special handling. Contact OptumRx for information on specialty drugs

Information About Medicare Part D Prescription Drug Plans

If you are entitled to Medicare Part A or enrolled in Medicare Part B, you can enroll in Medicare Prescription Drug Coverage (Medicare Part D). However, the Plan's prescription

drug coverage is “creditable,” which means the benefits are, on average, as good as or better than the standard Medicare coverage. Therefore, you do not have to enroll in Medicare Part D.

If you are an active employee and enroll in a Part D plan, your prescription drug benefits will remain the same and this Plan will coordinate with Medicare. If you are a retiree and you enroll in a Medicare Part D Prescription Drug Plan, you will not be eligible to receive prescription drug benefits under the Plan and you will not be able to re-enroll in the Plan for prescription drug coverage in the future. However, you can continue to receive medical benefits as long as you remain eligible for Plan coverage.

How to File an Appeal

For instructions on how to appeal a denied claim (in whole or in part) or any other adverse benefit determination, see the “Claims and Appeals Procedures” section.

OTHER BENEFITS PROVIDED BY THE WELFARE FUND

Department of Transportation Exams

If you are eligible for benefits under the Plan, you are covered for the following testing services/Department of Transportation (DOT) exams from CityMD or Clarity Testing:

- DOT Physicals (NRCME)
- DOT Drug and Alcohol Testing
- OSHA Respiratory Medical Clearance
- OSHA Fit Testing
- Hazmat Exams
- OSHA Lead Surveillance
- Hearing Conservation
- Firefighter Physicals
- Pre-Employment Physicals
- Asbestos Physicals

In order to receive these services from CityMD, you must contact the Fund Office for CityMD forms and bring these forms with you to your CityMD appointment. You will not be covered for these services at CityMD if you do not bring the appropriate form.

If you receive services from Clarity Testing, you do not need a form. Simply call Clarity Testing for an appointment at 888-LABMOBILE (888-522-6624), Monday through Friday, from 9:00 a.m. to 5:00 p.m. You can visit any of Clarity Testing at their two convenient locations:

- 150 White Plains Road, Suite 201, Tarrytown, NY 10591
- 45-10 Court Square, Long Island City, NY 11101

YOUR DENTAL BENEFITS

The Local 817 IBT Welfare Fund offers you the freedom to visit any dental care provider you would like and receive benefits for covered services. The benefit payable for charges made by a Preferred Care Provider is an amount equal to the Payment Percentage of the negotiated charge for the service or supply. The benefit payable for charges made by a provider that is not a Preferred Care Provider is an amount equal to the Payment Percentage of the Covered Dental Expense. The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses.

Advance Claim Review

If the cost of care to be provided to any one patient is expected to be $350 or more, the Plan suggests you to ask your dentist to submit the claim form in advance of treatment. Your claim will be reviewed and Aetna will estimate the benefits. You and the dentist will be told what they are before treatment starts.

As part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person at its own expense.
- You must give Aetna all diagnostic and evaluative material which it may require. These include x-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

Covered Dental Expenses

Certain dental expenses are covered. These are the dentists' charges for the services and supplies listed below which, for the condition being treated, are:

- Necessary; and
- Customarily used nationwide; and
- Deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

Alternate Treatment

In the event:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition,

The charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Maximum Benefits

The maximum benefit the Dental Plan will pay for dental expenses is $4,000 per person in a calendar year. The maximum benefit for orthodontia expenses is a lifetime maximum of $2,000 per person.

Schedule of Dental Expense Benefits

PROVISION	COVERAGE
How You Access Care	Go to any licensed dentist.
Annual Deductible	None
Annual Maximum Benefit	$4,000 per person per calendar year
Orthodontic Maximum	$2,000 per person lifetime maximum
Expense	Payment Percent
EXPENSE	**PAYMENT PERCENT**
TYPE A EXPENSES	
VISITS AND X-RAYS	**100%**
• Office visit during regular office hours, for oral examination – Routine comprehensive or recall examination (limited to 2 visits every year) – Problem-focused examination (limited to 2 visits every year)	
• Prophylaxis (cleaning) (limited to 2 treatments per year)	
• Topical application of fluoride (limited to one course of treatment per year and to children under age 16)	
• Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)	
• Bitewing X-rays (limited to one set per year)	
• Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)	
• Vertical bitewing X-rays (limited to 1 set every 3 years)	
SPACE MAINTAINERS Includes all adjustments within six months after installation	
• Fixed (unilateral or bilateral)	

EXPENSE	PAYMENT PERCENT
• Removal (unilateral or bilateral)	
Type B Expenses	
VISITS AND EXAMS	**85%**
• Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)	
• Emergency palliative treatment, per visit	
GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (Only When Provided In Conjunction With A Covered Surgical Procedure.)	
X-RAY AND PATHOLOGY	
• Periapical X-rays (single films) (up to 13)	
• Intra-oral, occlusal view, maxillary or mandibular	
• Upper or lower jaw, extra-oral	
• Biopsy and histopathologic examination of oral tissue	
ORAL SURGERY	
• Extractions – Exposed root or erupted tooth – Coronal remnants – Surgical removal of erupted tooth/root tip	
• Impacted Teeth – Removal of tooth (soft tissue)	
• Odontogenic Cysts and Neoplasms – Incision and drainage of abscess – Removal of odontogenic cyst or tumor	
• Other Surgical Procedures – Alveoplasty, in conjunction with extractions – per quadrant – Alveoplasty, not in conjunction with extractions – per quadrant – Sialolithotomy: removal of salivary calculus – Closure of salivary fistula – Excision of hyperplastic tissue – Removal of exostosis – Transplantation of tooth or tooth bud – Closure of oral fistula of maxillary sinus – Sequestrectomy – Crown exposure to aid eruption – Removal of foreign body from soft tissue – Frenectomy	

– Suture of soft tissue injury	
PERIODONTICS	
• Occlusal adjustment (other than with an appliance or by restoration)	
• Root planning and scaling, per quadrant, limited to 4 separate quadrants every 2 years	
• Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)	
• Gingivectomy per quadrant (limited to 1 per quadrant every 3 years)	
• Gingivectomy – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)	
• Gingival flap procedure, per quadrant (limited to 1 per quadrant every 3 years)	
• Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)	
• Periodontal maintenance procedures following active therapy (limited to 2 per year)	
• Localized delivery of chemotherapeutic agents	
ENDODONTICS	
Pulp capping	
• Pulpotomy	
• Apexification/recalcification	
• Apicoectomy	
• Root canal therapy, including necessary X-rays – Anterior • Bicuspid	
– RESTORATIVE DENTISTRY Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)	
Amalgam Restorations	
• Resin Restorations	
• Sedative Fillings	
• Pins • Pin retention – per tooth, in addition to amalgam or resin restoration	
• Recementation – Inlay – Crown – Bridge	
– ORAL SURGERY	

• Impacted Teeth – Removal of tooth (partially bony) Removal of tooth (completely bony)	
– PERIODONTICS	
Osseous surgery (including flap entry and closure) – per quadrant (limited to 1 per quadrant, every 3 years)	
• Osseous surgery (including flap entry and closure) – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)	
• Soft tissue graft procedures	
• Clinical crown lengthening, hard tissue	
ENDODONTICS	
• Root canal therapy, including necessary X-rays – Molar	
RESTORATIVE Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.	
• Labial Veneers – Laminate – chair side – Resin laminate – laboratory – Porcelain laminate – laboratory	
EXPENSE	**PAYMENT PERCENT**
TYPE C EXPENSES	
PROSTHODONTICS	85%
• Bridge Abutments (see Inlays and Crowns)	
• Crowns (when tooth cannot be restored with a filling material) – Prefabricated stainless steel – Prefabricated resin crown (excluding temporary crowns)	
• Inlays/Onlays – Metallic or Porcelain/Ceramic – Inlay, one or more surfaces – Onlay, two or more surfaces	
• Inlays/Onlays – Resin-based Composite – Inlay, one or more surfaces – Onlay, two or more surfaces	
• Crowns – Resin – Resin with noble metal – Resin with base metal – Porcelain – Porcelain with noble metal	

– Porcelain with base metal – Base metal (full cast) – Noble metal (full cast) – Metallic (3/4 cast) • Post and core • Core build up, including any pins	
• Pontics – Base metal (full cast) – Noble metal (full cast) – Porcelain with noble metal – Porcelain with base metal – Resin with noble metal – Resin with base metal	
PROSTHODONTICS *continued*	
• Removable Bridge (unilateral) – One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics	
• Dentures and Partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Specialized techniques and characterizations are not eligible. Note: Replacements, additions, or modifications of existing dentures, crowns, inlays, or bridgework are covered if they cannot be made serviceable and were installed at least five years before replacement.) – Complete upper denture – Complete lower denture – Partial upper or lower, resin base (including any conventional clasps, rests, and teeth) – Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth) – Stress breakers – Interim partial denture (stay plate), anterior only – Office reline – Laboratory reline – Special tissue conditioning, per denture – Rebase, per denture – Adjustment to denture more than six months after installation	
• Full and Partial Denture Repairs – Broken dentures, no teeth involved – Repair cast framework – Replacing missing or broken teeth, each tooth	
• Adding teeth to existing partial denture – Each tooth	

– Each clasp	
• Repairs: crowns and bridges	
• Occlusal guard (for bruxism only) limited to 1 every 3 years	
ORTHODONTICS	
Diagnosis and Treatment	60%, with a lifetime maximum of $2,000 per person

Special Provisions for Orthodontic Treatments

Orthodontia services for covered active and retired members are provided by Aetna at 60%. The lifetime maximum benefit is $2,000 per person.

Coverage for **orthodontic treatment** is limited to those services and supplies listed in the Summary of Coverage.

A dentist's charges for services and supplies for orthodontic treatment are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for orthodontic treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.

What's Not Covered by the Dental Plan (Exclusions and Limitations)

Covered Dental Expenses do not include and benefits are not payable for charges for:

- Any dental services and supplies which are covered in whole or in part:
  - Under any other part of this Plan; or
  - Under any other plan of group benefits provided by your policyholder.
- Services and supplies to diagnose or treat a disease or injury that is not:
  - A non-occupational disease; or
  - A non-occupational injury
- Services not listed in the Dental Care Schedule that applies, except as specifically provided.
- Replacement of a lost, missing, or stolen appliance, and/or replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Dentures; Crowns; Inlays; Onlays; Bridgework; or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.

- Any of the following services:
  - An appliance, or modification of one, if an impression for it was made before the person became a covered person;
  - A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  - Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Services intended for treatment of any jaw joint disorder, except as specifically provided.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Orthodontic treatment, except as specifically provided.
- General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.
- Treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- A crown, cast, or processed restoration unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high noble metals, except as specifically provided.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided.
- Services needed solely in connection with non-covered services.
- Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

YOUR OPTICAL BENEFITS

Optical Benefits are separately administered from Medical benefits and are considered "excepted benefits" under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA).

If you are covered medically, your optical benefits depend on whether you go to your own provider or use a participating vision care center.

- If you use your own provider, the Fund pays up to $220.00 for vision care expenses once every 12 months.
- If you use a Davis Vision provider, you can get an annual eye exam at no cost. Glasses and other corrective lenses are available at no cost or at a significant discount, depending on your selection.

Eligible Vision Care Expenses

The Plan covers the following eligible vision care expenses:

- Comprehensive eleven-point eye examination performed by a legally qualified and licensed ophthalmologist or optometrist
- Prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist
- Tinting for lenses, including sun-sensitive glasses
- Frames from the Tower Collection, available at most network provider offices, or a $195.00 retail allowance toward frames from the provider's own supply
- Contact lenses (in lieu of eyeglass lenses) including Bausch and Lomb, special, astigmatic and extended wear lenses
- Daily-wear, disposable or planned replacement contact lenses (in lieu of eyeglass lenses), or a $175 credit will be applied toward contact lenses from the provider's own supply. If you choose disposable contact lenses and are new to the provider or a first-time contact lens wearer, you will receive an initial supply (two multi-packs) of lenses, along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive four multi-packs of lenses.

Once the contact lens option is selected and the lenses fitted, they may not be exchanged for eyeglasses.

In-Network Benefits

To use an In-Network provider from Davis Vision, first contact Davis Vision or go on their Website to get the names and addresses of In-Network providers near you. Many of the participating providers have various locations, so be sure to ask for the location nearest you.

Network Provider	Phone Number	Website
Davis Vision	800-999-5431	www.davisvision.com

Once you decide on an In-Network provider, you should call to schedule an appointment with them. When you call the In-Network provider, identify yourself as a Theatrical Teamsters Local 817 Welfare Fund member or covered dependent. Furnish the provider with your Social Security number and date of birth of any of your covered children needing services. The provider's office will verify your eligibility for services. No claim forms or ID cards are required.

Once you decide on an In-Network provider, you should call to schedule an appointment with them. When you call the In-Network provider, identify yourself as a Theatrical Teamsters Local 817 Welfare Fund member or covered dependent. Furnish the provider with your Social Security number and date of birth of any of your covered children needing services. The provider's office will verify your eligibility for services. No claim forms or ID cards are required.

Out-of-Network Benefits

If you go to a provider who is not part of a network, you pay the full cost of the services and items you purchase. You must then submit a copy of the itemized bill to the Fund Office for reimbursement up to Plan limits.

Laser Vision Surgery

In addition to the optical benefits described above, the Fund will pay 50% of your eligible expenses for laser vision surgery, up to a lifetime maximum benefit of $2,500.

Ineligible Vision Care Expenses

The Plan's vision care coverage will not make payments for, or reimburse any part of, expenses incurred for, caused by, or resulting from:

- Expenses incurred for services payable under the provisions of any other benefit of the Plan.
- Non-prescription eyeglasses.
- Future laser vision enhancements are not included.

YOUR WEEKLY LOSS OF TIME BENEFITS

The Welfare Fund provides Weekly Loss of Time benefits for active members only. These benefits provide up to 26 weeks of income for active members who are unable to work due to non-work-related injuries or illness (including disability due to pregnancy). Benefits will not be paid for accidents or sickness arising out of or in the course of your employment.

Active members that are unable to work due to non-work-related disabilities may be eligible for up to 26 weeks of income.

If you are disabled because of illness or injury and you cannot work, you may be eligible for benefits from a number of sources. Workers' Compensation benefits are available if the injury is work-related. For non-job-related illness or injury, the Fund provides benefits insured through the Hartford Insurance Company. These benefits comply with the provisions of New York and New Jersey State Disability Benefits Laws. If you do not meet the eligibility requirements for health benefits set forth on page 5, you may still be eligible for benefits through Hartford Insurance Company at the New York and New Jersey statutory rates. Your benefits will begin on the eighth day of your disability and will continue for up to a maximum of 26 weeks with medical documentation. Benefits will not be paid if you are not under the care of a physician or other provider as defined in the applicable state law.

To receive benefits, you should advise the Fund Office of your disability no later than 30 days after your disability starts. To receive this benefit, you are required to furnish a completed disability form. For New York employees, the form is the DB-450. For New Jersey, the form is DS-1.

YOUR HOLIDAY AND VACATION BENEFITS

The following Holiday and Vacation benefits are available to eligible Active employees only.

Holiday Benefits

In order to receive payment for a holiday, you must accumulate at least 17-day units of work with contributing employers during the 30-day period preceding the holiday. You may not use vacation days toward holiday eligibility. However, if you are eligible for medical benefits, you will automatically qualify for all uncompensated holidays. You are not eligible for a holiday from the Welfare Fund if you work the holiday or it is unworked but you receive a "flat" as defined in the Union contract.

Vacation Benefits

You become eligible for Vacation benefits according to the following schedule:

VACATION TIME PERIOD	ELIGIBILITY REQUIREMENTS
One Week	Minimum of 200 day units of work with contributing employers during a calendar year for one week of vacation in the following year.
Two Weeks	Minimum of 200 day units of work with contributing employers during each of two consecutive calendar years for two weeks of vacation in the following year.
Three Weeks	Minimum of 200 day units of work with contributing employers during each of three consecutive calendar years for three weeks of vacation in the following year.
Four Weeks	If you meet the requirements for three weeks of vacation noted above, you will be entitled to four weeks of vacation if you qualify for the Welfare Plan for at least 15 consecutive years.
Five Weeks	If you meet the requirements for three weeks of vacation noted above, you will be entitled to five weeks of vacation if you qualify for the Welfare Plan for at least 25 consecutive years.

Here's an example of how your Vacation benefit may be affected if you don't earn 200 day units of work in a calendar year:

After qualifying for Vacation benefits, if you do not meet the minimum eligibility requirement of 200 day units in a calendar year, you will lose one week of vacation for the next calendar year. If you fail to accrue 200 day units for one year only, but you then make 200 days units in the next year, you will resume Vacation benefits. If you fail to make 200 day units for two consecutive years, you will have no vacation eligibility time. You then must qualify for vacation according to the eligibility requirements outlined in the above table.

Vacation does not need to be designated to a specific time period; you may request vacation at any time during the calendar year and request your entire vacation benefit. If you do not request it, it will automatically be sent to you in early December. Your vacation units will be applied to the current calendar year.

To find out more about your Holiday and Vacation benefits, you may e-mail your inquiries or request to codonnell@local817.com.

Important

Holiday and Vacation requests **must** be made NO LATER THAN 30 days after said holiday or the first day of requested vacation.

If you are eligible for a holiday, you **must** call for that holiday the work week AFTER the holiday falls.

YOUR LIFE INSURANCE BENEFITS

You are eligible for Life Insurance benefits while covered under this Plan. If you are eligible for retiree benefits, you are eligible for retiree life insurance. Your life insurance coverage, insured by the The Hartford, is $50,000 for active participants and $10,000 for retirees. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

Please note that in order to be eligible for Life Insurance benefits, you must be "available for work" – which means you have the required number of day units to maintain eligibility for Plan coverage, but are not currently working.

About Your Beneficiary

You may name or change your beneficiary by filing a written request with the Fund Office or Hartford. Contact the Fund Office for the applicable forms. Any designation of or change of a beneficiary will take effect as of the date you execute the request. Hartford will be fully discharged of its duties as to any payment made by it before your request is received by Hartford.

If you are an active member, your Life Insurance beneficiary is the same as your AD&D Insurance beneficiary unless you choose otherwise. Contact Hartford Life Insurance Company directly if you want to name a different beneficiary for AD&D Insurance.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your life insurance benefit will be payable in the following order:

- to your spouse, if any;
- if there is no spouse, in equal shares to your living children;
- if there is no spouse or child, to your parents, equally or to the survivor;
- if there is no spouse, child, or parent, in equal shares to your brothers and sisters;
- if none of the above survives, to your executors or administrators.

When your coverage ends, you can apply for a personal policy under the conversion privilege within 31 days after you lose coverage. If you die within 31 days of loss of coverage and before the personal policy goes into effect, the amount payable under the group contract is limited to the maximum that could be converted.

Claiming Life Insurance Benefits

Your beneficiary must notify the Fund Office in writing of your death. The Fund Office will send your beneficiary the appropriate claim form necessary to receive benefits from the Plan.

Life insurance claims will be considered for payment only if they are received within one year of the date of your death.

NOTE: *This is not a complete benefits comparison or a contract and should only be viewed as a brief summary to assist you in understanding the Hartford benefits program. A detailed benefits description, including information on accelerated death benefits, claiming benefits conversion, exclusions and claims and appeals is contained within the Certificate of Coverage. The terms, conditions, limits and exclusions shown in the Certificate of Coverage shall govern.*

YOUR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFITS

The Plan provides a benefit for Accidental Death & Dismemberment (AD&D) Insurance for active participants, which is insured by The Hartford.

How AD&D Benefits Work

Your AD&D Insurance coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you are severely injured in an accident (except those specifically excluded below). AD&D Insurance benefits are payable in addition to any other coverage you may have. Your beneficiary can be the same as your Life Insurance beneficiary on file with Hartford Life Insurance Company unless you choose otherwise.

LOSS: THE PLAN PAYS A BENEFIT IF, WHILE INSURED, YOU SUFFER A BODILY INJURY CAUSED BY AN ACCIDENT, AND IF WITHIN 365 DAYS AFTER THE ACCIDENT AND AS A DIRECT RESULT OF THE ACCIDENT, YOU LOSE:	**BENEFIT PAYABLE**
• **Life**	$50,000
• **Both hands at or above the wrist** • **Both feet at or above the ankle, or** • **Both eyes** • **Both hearing and speech, deemed total and permanent** • **Third degree burns covering 75% or more of the body caused by direct contact with a chemical, fire, steam, water or heat (except sunburn)** • **Quadriplegia**	$50,000
• **Loss of hearing or speech** • **One hand at or above the wrist** • **One foot at or above the ankle, or** • **Loss of one eye** • **Paraplegia or for hemiplegia** • **Third degree burns covering 50% to 74% of the body**	$25,000
• **Loss of the thumb and index finger of the same hand** • **Uniplegia**	$12,500

How a "loss" is defined. Loss of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of eyesight means the irrevocable and complete loss of sight. Your speech or hearing loss must be total and deemed permanent. A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending physician states otherwise. Your thumb and index finger of the same hand means by actual severance of entire digit. Loss of thumb and index finger means complete severance through or above the metacapophalangeal joint of both digits.

Only one amount—the largest to which the insured is entitled—will be paid for all losses resulting from a single accident. All claims should be reported promptly. The deadline for filing a claim for AD&D benefits is 90 days after the date of the loss causing the claim.

Contact Hartford Life Insurance Company to claim AD&D benefits. The Fund Office can provide you with a claim form.

What's Not Covered

- AD&D coverage is only for losses caused by accidents. No benefits are payable for a loss caused or contributed by:
- A bodily or mental infirmity.
- A disease or bacterial infection.[1]
- Medical or surgical treatment.[1]
- Suicide or attempted suicide.
- An intentionally self-inflicted injury.
- A war or any act of war (declared or not declared).
- Commission of or attempt to commit a felony.
- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).

When Coverage Ends

AD&D insurance coverage ends when your life insurance coverage ends and may not be converted.

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[1] These do not apply if the loss is caused by:
- An infection which results directly from the injury.
- Surgery needed because of the injury.
- Medical malpractice.

The injury must not be one which is excluded by the terms of this section.

Claiming AD&D Insurance Benefits

Claims must be submitted to Hartford in writing. You or your beneficiary should contact the Fund Office for the necessary claim forms. All claims should be reported promptly and within 90 days after the date of the loss causing the claim.

NOTE: *This is not a complete benefits comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the Hartford benefits program. A detailed benefits description, including limitations and exclusions and claims and appeals, is contained within the Certificate of Coverage. The terms, conditions, limits and exclusions shown in the Certificate of Coverage shall govern.*

HOW TO CLAIM BENEFITS

Internal Claims and Appeal Procedures

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

- For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.
- All notices sent to claimants relating to internal claims and appeal review for health benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling. Notices relating to internal review will be provided in Spanish upon request.
  - SPANISH (Español): Para obtener asistencia en Español, llame al 516-365-3470.

Where to File Claims

The following chart outlines when claims must be filed and to whom they should be sent. Your claim will be considered to have been filed as soon as it is received at the applicable address below by the organization that is responsible for determining the initial determination of the claim.

Benefit/Type of Claims Processed and Appropriate Claims Administrator	How to File Claims
Medical Benefits **Aetna Choice POS II** **Pre-Service Claims (including Urgent and Concurrent Claims)** **Post-Service Claims**	Contact Aetna Customer Service at the telephone number on your ID card. Claims involving Urgent Care must be submitted by telephone to Aetna by calling Customer Service at the toll free telephone number on your ID Card or visit Aetna's web site at www.aetna.com. If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna's Home Office at: Aetna Life Insurance Company PO Box 981106 El Paso, TX 79998-1106 Preferred Care There are no claim forms for Preferred Care providers. When you use a Preferred Care provider, you pay the cost-sharing amount, if any, directly to the provider. Non-Preferred Care If use a Non-Preferred Care provider for services, you will need to submit claim forms with original itemized bills or receipts to the address shown on your ID Card. Make copies for your records of the claim forms, itemized bills or receipts.
Prescription Drugs **OptumRx** **Pre-Service Drugs and Post-Service Claims for Out–of-Network Retail Drugs**	The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. See the Prescription Drug section for details on how to file a Pre-Service and Out-of-Network claim.

BENEFIT/TYPE OF CLAIMS PROCESSED AND APPROPRIATE CLAIMS ADMINISTRATOR	HOW TO FILE CLAIMS
Dental Claims	Contact Aetna Customer Service at the telephone number on your ID card. Claims involving Urgent Care must be submitted by telephone to Aetna by calling Customer Service at the toll free telephone number on your ID Card or visit Aetna's web site at www.aetna.com. If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna's Home Office at: Aetna Dental Claims PO BOX 14094 Lexington, KY 40512-4094
Vision Claims	In-Network Vision Claim A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from Davis Vision is not considered a claim. After the denial by Davis Vision, you may file a claim with the Plan. Submit Out-of-Network vision claim forms to the Fund Office: Local 817 IBT Theatrical Teamsters Welfare Fund 817 Old Cuttermill Road Great Neck, NY 11021 516-365-3470.
Life and Accidental Death & Dismemberment Insurance and Short-Term Disability/Weekly Accident and Sickness Claims	You should submit claims for Life Insurance or AD&D benefits to the Fund Office. If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit a claim or other information to you may contact the Fund Office. All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss. Claims for Weekly Accident & Sickness must be filed within 30 days of the loss. If, through no fault of your own, you are not able to meet the deadline for filing the claim, your claim will still be accepted if you file as soon as possible.

Benefit/Type of Claims Processed and Appropriate Claims Administrator	How to File Claims
A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you may be required to submit a completed claim form. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.	

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You can get a form from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Discretionary Authority Of Plan Administrator and Designees

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

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Adverse Benefit Determination

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

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate

in the Plan or a determination that a benefit is not a covered benefit;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Making Claims Determinations

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Health Benefit Claims

Health benefit claims can be filed for medical, prescription drug, dental and vision benefits. There are four categories of health claims as described below.

Pre-Service Claims. A Pre-Service Claim is any claim for medical care or treatment that requires advance approval of the benefit (in whole or in part) before medical care or treatment is obtained. The requirement that you obtain advanced approval of a non-urgent service, supply or procedures before a benefit will be payable is considered a pre-service claim. Under this Plan, prior approval of services is known as "pre-certification." Under this Plan, prior approval is required for medical, prescription drug, and dental benefits as outlined in those sections. Please refer to the Aetna Certificate of Coverage and the Summary of Coverage for details on what procedures constitute Pre-Service Claims as well as procedures that pertain to determination of Pre-Service Claims for Dental benefits.

Urgent Care Claims. An Urgent Care Claim is any claim for a medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize a person's life or health or ability to regain maximum function, or in the opinion of a physician with knowledge of the person's medical condition, would subject the person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Concurrent Care Claim/Ongoing Course of Treatment. A Concurrent Claim is a claim for care that involves an ongoing course of treatment to be provided over a period of time or through a number of treatments. Examples are extending a hospital stay or adding a number of visits to a provider.

Post-Service Claims. A Post-Service Claim is a claim submitted for payment after health services and treatment have been obtained. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Weekly Loss of Time (Disability) Claims

A Disability Claim is any claim that requires a finding of total disability as a condition of eligibility. Disability Claims should be submitted to The Hartford within 30 days after the date of disability. The "date of disability" is the first (1st) day of disability due to a non-work related injury, and the eighth (8th) day from the date you first lose time from work and are treated by a Physician because of disability due to an Illness. For Weekly Loss of Time benefit claims, the Plan reserves the right to have a physician examine you at the Plan's expense as often as is reasonable to determine your disability status. You will be notified of the determination of your Weekly Loss of Time benefits in accordance the applicable state law.

Life Insurance and Accidental Death & Dismemberment Insurance Claims

The Hartford will make a decision on a death benefit claim and notify your beneficiary within 90 days of receipt of the claim. If The Hartford requires an extension of time due to special circumstances, you will be notified of the reason for the delay and when the decision is expected to be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the end of the initial 90-day period.

Claim Elements

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

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

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);

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

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within 12 months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 18 months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit

determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date

Pre-Service Claims

Claims for Pre-Service (that are not for Urgent Care) will be decided no later than 15 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial 15-day period whether the claim was approved or denied (in whole or in part). The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if applicable) notification before the expiration of the initial 15-day determination period.

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

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

For Aetna Medical claims, if a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within 15 days of receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the receipt of the claim as described below.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the appropriate Claims Administrator or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours,

to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Concurrent Claims

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above as an Urgent Care Claim. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

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

Post-Service Claims

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

The time for deciding the claim may be extended by 15 days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 15 days to make a decision and notify you in writing (or electronically, as applicable).

Weekly Disability Claims – Decision Timeframes

Claims for Weekly Disability benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

Life Insurance/Accidental Death and Dismemberment Insurance – Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Claims Denial Notification

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

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;

- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- For Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Appealing a Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review.

Aetna Medical and Dental Appeals: You will have 180-days following receipt of an Adverse Benefit Determination (denial) to appeal the determination. You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. You may also call Member Services at the number on your ID card. You need to include your name, the Member/Participant's name, a copy of the adverse benefit determination, your reasons for making the appeal, any other information you would like Aetna to consider. You have two levels of appeals for Medical claims under this Plan. If you appeal a second time, you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision

Prescription Drug Appeals: You will have 180-days following receipt of an Adverse Benefit Determination (denial) to appeal the determination. You should submit your appeal to OptumRx at the address or phone number found on your ID card.

Appeal requests involving Urgent Care Claims may be made orally by calling Aetna or OptumRx at the telephone number listed on your ID card.

Out-of-Network Optical Appeals: Send all requests for Optical claim appeals to the Board of Trustees at:

Board of Trustees
Local 817 IBT Theatrical Teamsters Welfare Fund
817 Old Cuttermill Road
Great Neck, NY 11021

Appeals for Life Insurance and Accidental Death and Dismemberment claims should be sent to The Hartford at the address listed in the Certificate of Coverage. You should refer to the Certificate of Coverage for details on how to file appeals and the timing of the determination.

You can appeal a denial, in whole or part, of the **Weekly Loss of Time Benefit** to the New York Workers' Compensation Board or the New Jersey Division of Unemployment and Disability Insurance. The contact information will be found on your clam denial form.

Important Note: Your request for an appeal must be made in writing to the organization making the initial claims determination within 180 days after you receive notice of claim denial.

Appeal Procedure

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the

individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and
  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Timing of Notice of Decision on Appeal

You will be sent a notice of decision on review within the following time frames:

- **Urgent Aetna Medical Appeals – Expedited Appeals:** Aetna will render a decision involving Urgent and Pre-Service Claims within 36 hours of receipt of the necessary information to conduct the appeal.
- **Level One Pre-Service and Post-Service Aetna Medical and Dental Claims Appeals – Standard Appeals:** Aetna will issue a decision within 30 calendar days of receipt of the necessary information to conduct the appeal for a post-service appeal and 15 days for a pre-service appeal. If the Adverse Benefit Determination is upheld, the notice of appeal determination will include the reason for the determination (including the clinical rationale for it) and a notice of your right to an external appeal, together with information and a description of the external appeals processes. You will also have the option to request a Level Two appeal from Aetna.
- **Level Two Appeals for Pre-Service and Post-Service Medical and Dental Claims Appeals**: If you are dissatisfied with the outcome of your Level 1 Appeal, you may request a Level Two appeal. The Level Two appeal must be submitted within 60 calendar days following receipt of notice of a Level One appeal.
  - Aetna will issue a decision with 36 hours of receipt of the request for a Level Two appeal for an Urgent Care Claim.
  - Aetna will issue a decision with 15 calendar days of receipt of the request for a Level Two appeal for a Pre-Service Claim.
  - Aetna will issue a decision with 30 calendar days of receipt of the request for a Level Two appeal for a Post-Service Claim. You will receive an external appeal application when you receive the adverse determination from Aetna regarding your Level One appeal.

- **Prescription Drug Appeals**
  - **Urgent Appeal:** OptumRx will render a decision involving Urgent and Pre-Service Claims within 72 hours of receipt of the necessary information to conduct the appeal.
  - **Concurrent Claims:** A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.
  - **Pre-Service Appeal:** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by OptumRx. No extension of the Plan's internal appeal review timeframe is permitted.
  - **Post-Service Appeal:** A written (or electronic, as applicable) notice regarding the determination on the internal appeal will be sent to you within 60 days from the date your written request for an appeal is received by OptumRx. No extension of the Plan's internal appeal review timeframe is permitted.
- **Optical Post-Service Claims:** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice of Decision on Review

The Plan will notify you in writing of its decision on your appeal of a denied claim. This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- The following statement: "You and your Plan may have other voluntary alternative dispute

resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State insurance regulatory agency."

Please note that you may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. Although you must generally exhaust the Plan' internal appeal and external review processes before filing a lawsuit, Section 502(a) of the Employee Retirement Income Security Act permits you to start a lawsuit without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which the services were provided.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

External Appeal

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as short term disability benefits, vacation, life and AD&D benefits, and dental/vision benefits that are considered excepted benefits).
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

- Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:
- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

External Review of Standard (Non-Urgent) Claims

Your request for external review of a standard (not urgent) claim must made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Benefit Determination (generally the Explanation of Benefits for a claim) or adverse Appeal Claim Benefit

Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process, generally, must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for after an appeal has been denied.

An external review request on a standard claim should be made to the following applicable Plan designee:

- For all adverse Prescription Drug determinations: Optum Rx,
- For all adverse medical determinations, you must submit the Request for External Review Form to Aetna (at the address on the Form) within 123 calendar days (four months) of the date you received the decision from Aetna. You must include a copy of the notice from Aetna and all other important information that supports your request.

Preliminary Review of Standard Claims

Within five (5) business days of the appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

b. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

c. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

d. You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

a. If your request is complete and eligible for external review; or

b. 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)).

c. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) 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.

Review of Standard Claims by an Independent Review Organization (IRO)

If the request is complete and eligible for an external review, the appropriate Plan designee will assign the request to an IRO. (Note that 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 Plan may rotate assignment among 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, you are to submit such information within ten (10) business days).

b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan 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 Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan 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 Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

   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, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

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

f. The assigned IRO's decision notice will contain:

   – 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, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

   – The date that the IRO received the request to conduct the external review and the date

of the IRO decision;

- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan 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 Affordable Care Act to assist with external review processes.
- This Plan will also provide the Notice in Spanish, upon request.

External Review of Expedited Urgent Care Claims

You may request an expedited external review if:

a. you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an 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

b. you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination 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 for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, the appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

Review of Expedited Claim by an Independent Review Organization (IRO).

Following the preliminary review that a request is eligible for expedited external review, the appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

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, (described above under Standard Claims). 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 Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan 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 Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, 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 of the IRO's decision 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 Plan.

a. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

b. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

Incompetence

In the event it is determined that a claimant is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless the claim has been made therefore by a duly appointed guardian, committee or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant or such person having the claimant's power of attorney, as the Board of Trustees will determine in its sole discretion.

Cooperation

Every claimant will furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining, and administering the Fund. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and may from time to time adopt such formula, methods and procedures as the Board considers advisable.

Mailing Address

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

Recovery of Overpayment

If you are overpaid or otherwise paid in error for a claim, you must return the overpayment. The Board of Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error. Amounts recovered may include interest and costs.

In the event you are overpaid, the Fund Office will request a refund or the overpayment will be deducted from future benefits. Likewise, if payment is made on the eligible Plan participant's behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits, or a lawsuit may be initiated to recover the overpayment.

OTHER INFORMATION YOU SHOULD KNOW

Coordination of Benefits

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans may provide coverage for the same expense. To determine which plan pays first, the Plan follows a Coordination of Benefits (COB) provision.

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

For purposes of this section, the following terms apply. Allowable expense means a health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, *cosmetic surgery* generally is not an allowable expense under this plan.

In this section, "plan" means:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or participant benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Under the COB provisions, when this Plan is the primary plan, it will pay medical claims first as if the other plan does not exist. When this is the secondary plan, the Plan will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid. The Plan will never pay an amount that, together with payments from other coverage, add up to more than 100% of the allowable expenses.

Determining Who Pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

IF YOU ARE COVERED AS A:	PRIMARY PLAN	SECONDARY PLAN
Non-dependent or Dependent	The plan covering you as a participant or retired participant.	**The plan covering you as a dependent.**
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed.	
COB rules for dependent children		
Child of: **Parents who are married or living together**	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: **Parents separated or divorced or not living together** **With court-order**	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: The plan of the custodial parent pays first The plan of the spouse of the custodial parent (if any) pays second The plan of the noncustodial parents pays next The plan of the spouse of the noncustodial parent (if any) pays last	

IF YOU ARE COVERED AS A:	PRIMARY PLAN	SECONDARY PLAN
Active or inactive participant	The plan covering you as an active participant (or as a dependent of an active participant) is primary to a plan covering you as a laid off or retired participant (or as a dependent of a former participant).	A plan that covers the person as a laid off or retired participant (or as a dependent of a former participant) is secondary to a plan that covers the person as an active participant (or as a dependent of an active participant).
COBRA or state continuation	The plan covering you as an participant or retiree or the dependent of an participant or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an participant or retiree or the dependent of an participant or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

Benefits are paid as follows:

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.

Coordination with Medicare

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare. You are eligible for Medicare when you are covered under it by reason of age, disability, or end stage renal disease (ESRD). You are also eligible for Medicare even if you are not covered if you refused it, dropped it, or did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay

as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

How Coordination Works

IF YOU ARE ELIGIBLE DUE TO AGE AND HAVE GROUP HEALTH PLAN COVERAGE BASED ON YOUR OR YOUR SPOUSE'S CURRENT EMPLOYMENT AND:	PRIMARY PLAN	SECONDARY PLAN
You are active	This Plan	Medicare
You are retired	Medicare	This Plan
If you have Medicare because of:		
End stage renal disease (ESRD) You should enroll in Medicare Parts A and B as the Plan will coordinate with Medicare benefits to the extent allowable by law.	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare This Plan
A disability other than ESRD and the employer has more than 100 employees	This Plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are Benefits Paid?

We are primary	**We pay your claims as if there is no Medicare coverage.**
Medicare is primary	**We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.**

Right to Receive and Release Needed Information

The Plan and any Claims Administrators have the right to release or obtain any information we need for COB purposes. That includes information needed to recover any payments from your other health plans. In addition, sometimes another plan pays something that would have been paid under this plan. When that happens, this Plan's benefit will be paid to the other plan.

Right of Recovery

If the Plan or any Claims Administrator pays more than it should have under the COB rules, it may recover the excess from any person paid or for whom was paid, or any other plan that is responsible under these COB rules.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, Aetna may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered

Coordination with Medicaid. If your eligible dependent(s) have coverage from the Fund and Medicaid, the Fund will be the primary insurer.

Coordination with TRICARE. If both the Fund and TRICARE cover you and/or your dependent(s), the Plan pays first, and TRICARE provides secondary coverage.

Motor vehicle no-fault coverage required by law. If you and/or your dependent(s) are covered for medical benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Other coverage provided by state or federal law. If you and/or your dependent(s) are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first, and the Plan pays second.

Coordination with Workers' Compensation. If you're receiving benefits for a particular condition through Workers' Compensation insurance or a similar program, Workers' Compensation provides your primary and only coverage for that particular condition. Plan coverage remains in effect, excluding coverage for the particular condition that warranted Workers' Compensation benefits.

Coordination with Medicare Coverage for Active Employees. Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

- **Medical Participants Who Retain Or Cancel Coverage Under This Plan**

  If you, your covered spouse or dependent child become covered by Medicare, you may either retain or cancel your coverage under this Plan. If you choose to retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will

continue to provide the same benefits and your contributions for coverage will remain the same. The Plan will pay first and Medicare will pay second.

If you choose to cancel your coverage under this Plan, coverage of your Spouse and/or dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. Please refer to page 14 for further information about COBRA Continuation Coverage.

- **Coverage Under This Plan and Medicare When You Are Totally Disabled**

  If you become totally disabled and you are entitled to Medicare because of your disability, you will no longer be considered "actively employed." As a result, once you become entitled to Medicare because of your disability, Medicare will become your Primary Plan and will pay first, with this Plan paying second.

- **Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease**

  If, while you're actively employed, you or any of your covered dependents become entitled to Medicare because of End-Stage Renal Disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

  – The month in which Medicare ESRD coverage begins; or

  – The first month in which the individual receives a kidney transplant.

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

Coordination with Medicare Coverage for Retired Members. If you are retired and covered by Medicare Parts A, B, and/or a Medicare Advantage Plan (formerly called Medicare + Choice or Part C) ***without*** prescription drug coverage, as well as this Plan, Medicare pays first and this Plan pays second. Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. If a retiree under this Plan is covered by Medicare and cancels coverage under this Plan, coverage for his/her dependents will terminate, but they may be entitled to COBRA Continuation Coverage. See the Continuation of Coverage chapter for further information about COBRA Continuation Coverage.

This Plan pays the difference between normal Plan benefits and the amount paid by Medicare. Combined payments under Medicare and this Plan will not exceed the total amount normally payable under this Plan.

This Plan will pay benefits as if you are enrolled for all Medicare Parts A and B benefits that you would be eligible for regardless of whether or not you enrolled in Medicare. So, even if you do not enroll in Medicare Parts A and B when you are eligible, the Plan will pay retiree benefits as if Medicare were also making payments on your behalf.

Important Note: Medicare Part D Prescription Drug Coverage

If you, as a Medicare-eligible pensioner and/or your Medicare-eligible dependents, enroll in a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Plan (formerly called Medicare + Choice or Part C) with prescription drug coverage (MA-PD) – including the HIP option – your prescription drug benefits under this Plan will be terminated and you will no longer be eligible to receive any prescription drug benefit under this Plan. However, you will still be able to continue your hospital and medical coverage.

ADDITIONAL INFORMATION

Records of expenses**.** You should keep complete records of your expenses. They may be needed for a claim. Things that would be important to keep include names of physicians, dentists and others who furnish services, dates expenses are incurred and copies of all bills and receipts.

Assignment of Benefits

When you see a network provider they will usually bill the Network directly. When you see an out-of-network provider, the Claims Administrator may choose to pay you or to pay the provider directly. Unless there is an agreed to do so in writing and to the extent allowed by law, the Plan or any Claims Administrator will not accept an assignment to an out-of-network provider or facility under this plan. This may include the benefits due, the right to receive payments or any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

Financial Sanctions Exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, the Plan cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of Overpayments

Sometimes you or your provider are paid too much for **eligible health services** or pay for something that this Plan doesn't cover or have paid in error. If this happens, the Plan has a right to require the return of the overpayment on a request from the party that was paid – you or your provider. The Plan also has the right to reduce the amount of the overpayment from any future benefit payment to on behalf of that person or another person in his or her family covered under the plan.

Subrogation and Right Of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage). Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim. In particular, the Fund's equitable lien will not be reduced by any attorney's fees, court costs or disbursements that you and/or your attorney might incur in any legal action you take to recover from the third party and these expenses may not be used to offset your obligation to restore the full amount of the lien to the Fund. Further, any recovery you receive will not be reduced by, and is not subject to, the application of the common fund doctrine for the recovery of attorney's fees. Note that the Fund has an equitable lien on and the right of first reimbursement out of any recovery you obtain, even if you are not fully compensated for your loss.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to

provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Confidentiality of Health Care Information

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official *HIPAA Privacy Notice*, which is distributed to all participants of the Plan.

HIPAA: Use and Disclosure of Protected Health Information

Effective April 14, 2004, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like this Plan, maintain the privacy of your personally identifiable health information (called Protected Health Information or

PHI). Please note that the Aetna maintains policies and procedures as they pertain to the insured medical, prescription drug and dental benefits.

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

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which distributed to you upon enrollment in the Plan and is also available from the Fund Office. For a copy of Aetna's Notice of Privacy Practices, please contact them at the number that can be found on your ID card. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (insert name of plan sponsor), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan's Use and Disclosure of PHI: The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

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

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

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

Health Care Operations includes, but is not limited to:

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

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

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

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

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

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

When an Authorization Form is Needed: Generally the Plan will require that you sign a valid authorization form (available from the Fund Office or Aetna) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

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

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

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

3. Not use or disclose the information for employment-related actions and decisions;
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

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

- The Plan Manager,
- Staff designated by the Plan Manager.
- Business Associates under contract to the Plan including but not limited to the vision claims administrator.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer [whose address and phone number are listed on the Quick Reference Chart in the front of this document].

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Fund Office or Aetna at the number on your ID card.

In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it

creates, receives, maintains or transmits on behalf of the group health plan,

2. Will ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

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

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected in the following situations.

- You or your beneficiary do not file a claim for benefits properly or on time.
- You or your beneficiary do not furnish the information required to complete or verify a claim.
- You or your beneficiary do not have your current address on file with the Fund Office.

You should also be aware that Fund benefits are not payable for enrolled dependents who become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA benefits, described on page 14).

If the Plan mistakenly pays a larger benefit than you're eligible for, or pays benefits that were not authorized by the Plan, including to an ineligible person, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error (also see "Subrogation," page 114).

Compliance With Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, current federal tax law and the Employee Retirement Security Act of 1974 (ERISA). The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law takes precedence over state law.

Amendment and Termination of the Plan

The Trustees of the Fund reserve the right to amend or terminate the Plan at any time and for any reason. You will be notified via mail if the Plan is amended or terminated; however, the change may be effective before notice is delivered to you.

If the Plan is terminated, Plan assets will be applied to provide benefits in accordance with the applicable provisions of federal law.

Your Disclosures to the Plan

If you provide false information to the Plan or commit fraud, you may be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check, knowingly cashing a voided check or enrolling an ineligible person in the Plan.) What's more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges to the extent permitted by law.

Plan Administration

The Fund is a welfare benefit plan. Fund assets are accumulated under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

Discretionary Authority of the Board of Trustees

The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret facts,, determine benefit eligibility and resolve ambiguities or inconsistencies in the terms of the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan and should receive judicial deference to the extent they do not constitute an abuse of discretion.

The Board of Trustees has delegated certain administrative and operational functions to the Fund Manager and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff. The Fund Manager also has the discretion to make factual determinations arising under the Plan, determine benefits eligibility and resolve ambiguities or inconsistencies in the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Fund Manager or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected and should receive judicial deference to the extent they do not constitute an abuse of discretion.

Employer Contributions

The Fund receives contributions according to collective bargaining agreements between your employer and Local 817 IBT Theatrical Teamsters. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered employee on a specified basis. Certain other employers (such as the Fund Office itself) may participate in the Plan by signing a participation agreement. A copy of the collective bargaining agreements may be obtained upon written request to the Fund Administrator and is available for examination by participants and beneficiaries.

To find out whether a particular employer is contributing to the Fund on behalf of members working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office.

GLOSSARY

TERM	DEFINITION
Active Participant/Participant	The active Employee who has enrolled for coverage under the Plan.
Aetna	Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.
Ambulance	A vehicle staffed by medical personnel and equipped to transport an ill or injured person.
Ancillary Services (with respect to a participating health care facility)	1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; 2. Items and services provided by assistant surgeons, hospitalists, and intensivists; 3. Diagnostic services, including radiology and laboratory services; and 4. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
Behavioral Health Provider	An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.
Benefits	The Welfare Benefits provided pursuant to this Plan.
Body Mass Index	This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.
Brand-Name Prescription Drug	A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.
Calendar Year	The 12-month period beginning January 1 and ending December 31.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. See the section entitled “COBRA Continuation Coverage” in this document for more information.
Collective Bargaining Agreement	The Collective Bargaining Agreements in force and in effect between the Union and Contributing Employers, together with any modifications or amendments thereto.

TERM	DEFINITION
Continuing Care Patient	An individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition", (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the Provider or facility.
Contract Year	The 12-consecutive-month period of the policy or administrative services contract under which Plan benefits are provided. The Contract Year is not the same as the Plan Year. See also the definitions of Calendar Year and Plan Year.
Contributions	The payments made by Employers to the Welfare Plan.
Coordination of Benefits (COB)	The rules and procedures applicable to determination of how medical benefits are payable when a person is covered by two or more such care plans.
Copay or Copayments	The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.
Cosmetic	Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.
Covered Benefits	Eligible health services that meet the requirements for coverage under the terms of this plan, including: 1. They are medically necessary. 2. You received precertification, if required.
Covered Employment	Work performed under a Collective Bargaining Agreement for which contributions must be paid to this Fund.
Custodial Care	Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.
Deductible	The amount you pay for eligible health services per Calendar Year before your plan starts to pay as listed in the schedule of benefits.
Dependents	Your legal Spouse or your unmarried child as defined in the Eligibility section of this document once you have enrolled them for coverage.

TERM	DEFINITION
Detoxification	The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the: • Intoxicating alcohol or drug • Alcohol or drug-dependent factors • Alcohol in combination with drugs This could be done by metabolic or other means determined by a physician. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.
Directory	The list of network providers for your plan. The most up-to-date directory for your plan appears at **www.aetna.com**under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for providers that participate in your specific plan. Network providers may only be considered for certain plans.
Durable Medical Equipment (DME)	Equipment and the accessories needed to operate it, that is: • Made to withstand prolonged use • Mainly used in the treatment of an illness or injury • Suited for use in the home • Not normally used by people who do not have an illness or injury • Not for altering air quality or temperature • Not for exercise or training
Effective Date of Coverage	The date you and your dependent's coverage begins under this booklet as noted in the policyholder's records.
Eligible Health Services	The health care services and supplies listed in the Eligible health services under your plan section and not carved out or limited in the exclusions section or in the schedule of benefits.
Emergency Admission	An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

TERM	DEFINITION
Emergency Medical Condition	A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in 1. Serious impairment to bodily functions; or 2. Serious dysfunction of any bodily organ or part; or 3. Placing the health of an individual or an unborn child in serious jeopardy.

TERM	DEFINITION
Emergency Services	a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department (some urgent care facilities, but not all, qualify), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and b. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). c. Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until: 1. The Provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and 2. You are supplied with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Welfare Fund, of the estimated charges for your treatment and any advance limitations that the Welfare Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and 3. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.
Employee	An individual who is covered by a Collective Bargaining Agreement or Participation Agreement that requires his or her Employer to make contributions to this Fund on his or her behalf. Contributions on an Employee's behalf are made in accordance with the applicable Agreement.
Employer	An Employer making contributions to the Welfare Plan under a Collective Bargaining Agreement with the Local 817 IBT Welfare Fund.

TERM	DEFINITION
Enroll or Enrollment	The process of completing and submitting a written enrollment form indicating that coverage under the Plan is requested by the Employee.
ERISA	The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. See the section entitled "Your Rights under ERISA" in this booklet for more information.
Experimental or Investigational	A drug, device, procedure, or treatment that is found to be experimental or investigational because: • There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved • The needed approval by the FDA has not been given for marketing • A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes • It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services • Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.
FMLA	The Family and Medical Leave Act of 1993, as amended. See the section entitled "Coverage During a Leave (Special Circumstances) for more information.
Generic Prescription Drug	A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.
Geographic Area	The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

TERM	DEFINITION
Health Care Facility (for Non-Emergency Services)	1. A hospital (as defined in section 1861(e) of the Social Security Act); 2. A hospital outpatient department; 3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and 4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act
Health Professional	A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, and physical therapists.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, as amended.
Home Health Care Agency	An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.
Home Health Care Plan	A plan of services prescribed by a physician or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound.
Hospice Care	Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.
Hospice Care Agency	An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.
Hospice Care Program	A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.
Hospice Facility	An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.

TERM	DEFINITION
Hospital	An institution licensed as a hospital by applicable state and federal laws, and is accredited as a hospital by The Joint Commission (TJC). Hospital does not include a: • Convalescent facility • Rest facility • Nursing facility • Facility for the aged • Psychiatric hospital • Residential treatment facility for substance abuse • Residential treatment facility for mental disorders • Extended care facility • Intermediate care facility • Skilled nursing facility
Illness	Poor health resulting from disease of the body or mind.
Infertile or Infertility	A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg- sperm contact for women under age 35 (or 6 months for women age 35 or older).
Injury	Physical damage done to a person or part of their body.
Institutes of Excellence™ (IOE) Facility	A facility designated by Aetna in the provider directory as Institutes of Excellence network provider for specific services or procedures.
Intensive Outpatient Program (IOP)	Clinical treatment provided in a facility or program provided under the direction of a physician. Services are designed to address a mental disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.
Jaw Joint Disorder	This is: • A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint, • A Myofascial Pain Dysfunction (MPD) of the jaw, or • Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.
L.P.N.	A licensed practical nurse or a licensed vocational nurse.
Mail Order Pharmacy	A pharmacy where prescription drugs are legally dispensed by mail or other carrier.

TERM	DEFINITION
Maximum Out-of-Pocket Limit	The maximum out-of-pocket amount for payment of copayments and payment percentage, to be paid by you or any covered dependents per Calendar Year for eligible health services.
Medically Necessary or Medical Necessity	Health care services that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: • In accordance with generally accepted standards of medical practice • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease • Not primarily for the convenience of the patient, physician, or other health care provider • 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 • Generally accepted standards of medical practice means: • Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. • Consistent with the standards set forth in policy issues involving clinical judgment.

TERM	DEFINITION
Medicare Allowable Rates	Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows: • Use the same method CMS uses to set Medicare rates. • Look at what other providers charge. • Look at how much work it takes to perform a service. • Look at other things as needed to decide what rate is reasonable for a particular service or supply. **Additional information:** Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna's secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.
Member	The active Employee who has enrolled for coverage under the Plan.
Mental Disorder	An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatrist, a psychologist or a psychiatric social worker. Mental disorder includes substance related disorders.
Morbid Obesity or Morbidly Obese	This means the body mass index is well above the normal range and severe medical conditions may also be present, such as: • High blood pressure • A heart or lung condition • Sleep apnea or • Diabetes
Negotiated Charge	The amount a network provider has agreed to accept for rendering services or providing prescription drugs or supplies to members of your plan.
Network Provider	A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not a network provider.
NMHPA	The Newborns' and Mothers' Health Protection Act of 1996, as amended. See the sub-section "Hospital Length of Stay for Childbirth" in the section entitled "Other Important Information."

TERM	DEFINITION
No Surprises Services	1. Out-of-Network Emergency Services; 2. Out-of-Network air ambulance services; 3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and 4. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network Provider at an In-Network health care facility with respect to which the provider does not comply with federal notice and consent requirements.
Out-of-Network Pharmacy	A pharmacy that is not a network pharmacy or a National Advantage Program (NAP) provider and does not appear in the directory for your plan.
Out-of-Network Provider	A provider who is not a network provider.
Partial Hospitalization Treatment	A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat mental disorders and substance abuse. The treatment plan must meet these tests: • It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full- time inpatient basis. • It is in accordance with accepted medical practice for the condition of the person. • It does not require full-time confinement. • It is supervised by a psychiatrist who weekly reviews and evaluates its effect.
Participant	The Employee or former Employee who has enrolled for coverage under the Plan. As used in this document, this term does not include the Spouse or Dependent Child(ren) of the Plan Participant.
Participation Agreement	An agreement between the Trustees of this Fund and an Employer.
Payment Percentage	The specific percentage you have to pay for a health care service listed in the schedule of benefits.
Pharmacy	An establishment where prescription drugs are legally dispensed. This includes a retail, mail order and specialty pharmacy.
Physician	A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

TERM	DEFINITION
Plan Administrator	The Board of Trustees of the Welfare Plan is the legal entity which has the fiduciary responsibility for the overall administration of the Plan and which serves as the Plan Administrator pursuant to the Employee Retirement Income Security Act of 1974 (ERISA).
Plan or This Plan	The programs, benefits, and provisions described in this document and the applicable appendices.
Plan Year	The 12-month period from January 1 to December 31 designated to be the Plan Year. The Contract Year is not the same as the Plan Year. See also the definitions of Calendar Year and Contract Year.
Precertification or Precertify	A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.
Prescriber	Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.
Prescription	A written order for the dispensing of a prescription drug by a prescriber. If it is a verbal order, it must promptly be put in writing by the network pharmacy.
Prescription Drug	An FDA approved drug or biological which can only be dispensed by prescription.
Primary Care Physician (PCP)	A physician who: • The directory lists as a PCP • Is selected by a person from the list of PCPs in the directory • Supervises, coordinates and provides initial care and basic medical services to a person as a family care physician, an internist or a pediatrician • Is shown on Aetna's records as your PCP
Provider(s)	A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).
Psychiatric Hospital	An institution specifically licensed as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, mental disorders, or mental illnesses.

TERM	DEFINITION
Psychiatrist	A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.
Qualified Medical Child Support Order (QMCSO)	A support order of a state or administrative agency that usually results from a divorce or legal separation, complies with requirements of federal law, requires an Employee to provide health care coverage for a Dependent Child, and requires that benefits payable on account of that Dependent Child be paid directly to the health care provider who rendered the services or to the custodial parent of the Dependent Child.
Qualifying Payment Amount or QPA	Generally the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR 716-6(c).
R.N.	A registered nurse.
Recognized Amount	An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; 1. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or 2. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount ("QPA"). For air ambulance services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the Provider or facility or the QPA.
Recognized Charge	The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider's full charge. Your plan's recognized charge applies to all out-of-network eligible health services except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. In all cases, the recognized charge is determined based on the Geographic area where you receive the service or supply. Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and: • For professional services and for other services or supplies not mentioned below: o 225% of the Medicare allowable rate • For services of hospitals and other facilities:

TERM	DEFINITION
	o 200% of the Medicare allowable rate The recognized charge is the negotiated charge for providers with whom we have a direct contract or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of Aetna. If your ID card displays the National Advantage Program (NAP) logo, the recognized charge is the rate we have negotiated with your NAP provider. Your out-of-network cost sharing applies when you get care from NAP providers, except for emergency services. A NAP provider is a provider with whom we have a contract through any third party that is not an affiliate of Aetna or through the Coventry National or First Health Networks. However, a NAP provider listed in the NAP directory is not a network provider. We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as: • The duration and complexity of a service • When multiple procedures are billed at the same time, whether additional overhead is required • Whether an assistant surgeon is necessary for the service • If follow up care is included • Whether other characteristics modify or make a particular service unique • When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and • The educational level, licensure or length of training of the provider • Aetna reimbursement policies are based on our review of: • The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate • Generally accepted standards of medical and dental practice and • The views of physicians and dentists practicing in the relevant clinical areas

TERM	DEFINITION
	We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.
Residential Treatment Facility (Mental Disorders)	• An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided: o The Joint Commission (TJC) o The Committee on Accreditation of Rehabilitation Facilities (CARF) o The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) o The Council on Accreditation (COA) • In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders: • A behavioral health provider must be actively on duty 24 hours per day for 7 days a week. • The patient must be treated by a psychiatrist at least once per week. • The medical director must be a psychiatrist. • Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

TERM	DEFINITION
Residential Treatment Facility (substance abuse)	• An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided: o The Joint Commission (TJC) o The Committee on Accreditation of Rehabilitation Facilities (CARF) o The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) o The Council on Accreditation (COA) • In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs: • A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming. • The medical director must be a physician. • Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution). • In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting: • An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting. • Residential care must be provided under the direct supervision of a physician.
Room and Board	A facility's charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.
Semi-Private Room Rate	An institution's room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

TERM	DEFINITION
Serious and Complex Condition	1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent; or 2. In the case of a chronic illness or condition, a condition that is the following: a. Life-threatening, degenerative, potentially disabling, or congenital; and b. Requires specialized medical care over a prolonged period of time.
Skilled Nursing Facility	A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care. Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services. Skilled nursing facility does not include institutions that provide only: • Minimal care • Custodial care services • Ambulatory care • Part-time care services It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.
Skilled Nursing Services	Services provided by an R.N. or L.P.N. within the scope of his or her license.
Specialist	A physician who practices in any generally accepted medical or surgical sub-specialty.
Spouse	The Employee's lawful Spouse as determined by applicable state law.
Stay	A full-time inpatient confinement for which a room and board charge is made.
Substance Abuse	This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

TERM	DEFINITION
Surgery Center	A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).
Surgery or Surgical Procedures	The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.
Terminal Illness	A medical prognosis that you are not likely to live more than 12 months.
Trustees/Board of Trustees	The term "Employer Trustees" are the Trustees appointed by the Employers. The term "Union Trustees" are the Trustees appointed by the executive board of the Union. The Term "Trustees" or "Board of Trustees" are the Employer Trustees and Union Trustees collectively and includes their successors when acting as Trustees.
Union	The Local 817 IBT
Urgent Care Facility	A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.
Urgent Condition	An illness or injury that requires prompt medical attention but is not an emergency medical condition.
Walk-In Clinic	A free-standing health care facility. Neither of the following should be considered a walk-in clinic: • An emergency room • The outpatient department of a hospital
WHCRA	The Women's Health and Cancer Rights Act of 1998, as amended. See the sub-section "Breast Reconstruction Surgery Following Mastectomy" in the section entitled "Other Important Information."
You or Your	When used in this document, these words refer to the Employee who is covered by the Plan. They do not refer to any Dependent of the Employee.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Information About Your Plan and Benefits

As a participant in the Local 817 IBT Theatrical Teamsters 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:

- Examine, without charge, at the Fund Office and at other specified locations, such as the union hall, all Plan documents, including collective bargaining agreements, and copies of all documents, such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "Qualifying Event." You or your dependents may have to pay for such coverage. The Fund recommends that you review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a 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 the Plan, you should contact the Plan Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

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

PLAN FACTS

Official Plan Name	Local 817 IBT Theatrical Teamsters Welfare Fund	
Employer Identification Number (EIN)	13-6210566	
Plan Number	501	
Plan Year	January 1 to December 31	
Type of Plan	Welfare Health Plan providing group life insurance and comprehensive medical, prescription drug, vision, dental and disability benefits.	
Type of Administration	The Plan is administered and maintained by a joint board of trustees, appointed by the Union and by sponsoring employers.	
Funding of Benefits	The Fund is funded through employer contributions pursuant to Collective Bargaining Agreements or other written documents.	
	Insured Benefits HIP HMO Weekly Loss of Time and New York Paid Family Leave (PFL) Benefits Life Insurance Accidental Death & Dismemberment Insurance	**Self-insured Benefits** Medical Benefits (Administered by Aetna) Prescription Drug Benefits (Administered by OptumRx) Dental Benefits (Administered by Aetna) Vision Benefits (Administered by Davis Vision)
Trust	Contributions to the Local 817 IBT Theatrical Teamsters Welfare Fund are held in a trust pursuant to the Trust Agreement.	
Plan Sponsor and Administrator	The Local 817 IBT Theatrical Teamsters Welfare Fund is sponsored and administered by a joint Board of Trustees. The office of the Board of Trustees may be contacted at: Board of Trustees Local 817 IBT Theatrical Teamsters Welfare Fund 817 Old Cuttermill Road Great Neck, NY 11021 516-365-3470	

Board of Trustees	**Union Trustees** Thomas J. O'Donnell Francis J. Connolly, Jr. Brian Salomone **Employer Trustees** Greg Carlesimo James Arata Allan Kharieh
Agent for Service of Legal Process	The Board of Trustees has been designated as the agent for the service of legal process. Legal process may be served at the Fund Office and on the individual Trustees.
Write to the Board of Trustees at the address listed above if you want to:	Find out if a particular employer or employee organization is a contributing employer or sponsors the plan; obtain the address of a contributing employer; or, obtain a copy of collective bargaining agreements that apply to you. The Fund may charge a reasonable amount for the copy.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

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

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

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

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

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

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

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

o Cover emergency services by out-of-network providers.

o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal Department of Health and Human Services at 800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

If you have questions about this notice or would like more information about the dates that will apply to your rights under the Plan as they relate to special enrollment, COBRA or claims and appeals rights, please contact the Fund Office.

LOCAL 817 WELFARE FUND

817 Old Cuttermill Road
Great Neck, NY 11021
Phone: 516-365-3470
Fax: 516-365-2609
Website: 817benefits.org