



Summary Plan Description

I.A.T.S.E. NATIONAL HEALTH AND WELFARE FUND PLAN A

Effective June 1, 2020





From the Board of Trustees

June 1, 2020

Dear Participant:

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

- Hospital and medical coverage through Empire BlueCross BlueShield;
- Prescription drug benefits through CVS Health;
- Dental benefits through Delta Dental or, if you live in New York, through Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS) if you choose that option;
- Vision services through Davis Vision;
- Weekly Accident and Sickness benefits through the Metropolitan Life Insurance Company (MetLife); and
- Life insurance through MetLife.

This SPD provides a description of Plan A provisions in effect as of June 1, 2020.

After reading this SPD, if you have questions about the Plan or would like more information, please contact the Fund Office. A staff member will be pleased to assist you with any questions or concerns you may have. You can find contact information for the Plan and our benefit partners at the end of this SPD.

Sincerely,

The Board of Trustees

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Introduction

The I.A.T.S.E. National Health & Welfare Fund (referred to in this SPD as “the Fund”) was set up to provide health care benefits to eligible participants and their enrolled dependents. The Fund was established by various collective bargaining agreements between employers and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada (I.A.T.S.E.) and its Affiliated Locals (collectively, the “Union”). These collective bargaining agreements are contracts between employers and the Union that, among other things, require employers to contribute to the Health & Welfare Fund on behalf of employees who are working in covered employment.

The Plan is administered by a Board of Trustees, made up of an equal number of representatives appointed by the I.A.T.S.E. and the contributing employers. The Board of Trustees acts on behalf of you and your fellow Plan participants to manage all aspects of the Fund’s benefits operations and the administration of such benefits.

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

You receive this booklet when you first enroll. If you lose coverage and later return, you can request another copy of this SPD by calling 1-800-456-FUND (3863), writing to psc@iatsenbf.org or viewing/downloading it at www.iatsenbf.org. New updated booklets are sent upon their revision with any important change notices mailed to you intermittently.

This SPD describes the Plan provisions as of June 1, 2020. The Fund Office will communicate future changes to the benefits and eligibility rules through newsletters and/or other notices. Be sure to read all mail from the Fund Office carefully and keep all announcements of Plan A changes with this SPD for easy reference. You can also generally find updates on the Fund’s website by logging on to www.iatsenbf.org or through email at psc@iatsenbf.org.



**You can contact the
Fund Office at:
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& Welfare Fund
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Third Floor
New York, NY
10016-2204
(212) 580-9092
1-800-456-3863**



Your Role in Managing Your Benefits

You need to play an active role in managing your benefits to ensure that health care coverage for yourself and your eligible dependents begins when you or your dependents become eligible and continues uninterrupted for as long as you and your dependents remain eligible.

The Fund provides resources to help you track the number of days you have worked in covered employment. Please remember that covered employment only includes the days for which the Fund receives a contribution from your employer on your behalf. You can get the information you need online or through an interactive voice response (IVR) telephone system. Regardless of how you choose to access the information, it's your responsibility to do so—and to contact the Fund Office if you have any concerns.

It is essential that you keep Plan records (for example, your contact information, marital status, beneficiary information and dependents) up to date. If the Fund has incorrect information on file, your coverage may not begin when you would be otherwise eligible.

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

You receive this booklet when you first enroll. If you lose coverage and later return you can request another copy of this SPD by calling 1-800-456-FUND (3863), writing to psc@iatsenbf.org or viewing/downloading it at www.iatsenbf.org. New updated booklets are sent upon their revision with any important change notices mailed to you intermittently.



Benefits at a Glance

The following table provides a brief overview of the benefits available under Plan A. These include:

- Hospital and medical coverage for you and your covered dependents through Empire BlueCross BlueShield;
- Prescription drug benefits for you and your covered dependents through CVS Health;
- Dental benefits for you and your covered dependents through Delta Dental or, if you live in New York and actively choose, Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS);
- Vision services for you and your covered dependents through Davis Vision;
- Life insurance for you through the Metropolitan Life Insurance Company (MetLife);
- Weekly accident and sickness benefits for you through MetLife; and

The I.A.T.S.E. National Health and Welfare Fund also offers a retiree health benefit plan for you and your spouse if you meet the eligibility requirements.

Please note that any benefit limitations and exclusions are listed in detail further on in the SPD. The following table just provides a summary.



Hospital and Health Benefits Provided Through Empire BlueCross BlueShield

In-network, out-of-network

Plan A offers in-network and out-of-network benefits. All reimbursements of eligible out-of-network expenses are paid as a percentage of Empire BlueCross BlueShield's maximum allowed amount, which is the maximum Empire will pay for any service or supply. If an out-of-network provider charges more than the maximum allowed amount, you will be responsible for the excess, in addition to your normal coinsurance. In addition, limits on how many services or how often you can get services are applied to both in-network and out-of-network care combined.

Precertification Requirement &

Precertification is required for inpatient admissions and certain treatments and procedures to ensure the highest quality care for the right length of time in the right setting with maximum coverage. If you fail to precertify, penalties may apply, or you may lose coverage for that expense entirely. See page 23 for details on how the Medical Management Program works and what your responsibilities are.

Features	In-Network	Out-of-Network
Calendar Year Deductible	\$0	\$200/ Individual \$500/Family
Coinsurance	N/A	You pay 20% of the maximum allowed amount and the Plan pays 80% of the maximum allowed amount
Annual Out-of-Pocket Coinsurance Maximum	\$500/Individual	\$1,200/ Individual, includes deductible
	\$1,250/Family	\$3,000/ Family, includes deductible
Lifetime Maximum	Unlimited	Unlimited
Claim Forms to File	None	Yes
Annual Maximum Benefit	Unlimited	Unlimited

Benefits	In-Network	Out-of-Network (Shown below is how much you pay after you meet the deductible)
Doctor's Office Visits, Including Specialists	\$12/visit	20% coinsurance
Chiropractic Visits.	\$12/visit	20% coinsurance
Annual Physical Exam	Covered at 100% with no copayment/visit	20% coinsurance
Acupuncture Treatment	\$12/visit	20% coinsurance
Preventive Care/Screening/ Immunization	Covered at 100% with no copayment/visit	20% coinsurance
Allergy Care Office Visit	\$12/visit	20% coinsurance
Allergy Testing	\$0	20% coinsurance
Allergy Treatment	\$0	20% coinsurance
Well Woman Care Office Visits	\$0/visit	20% coinsurance
Pap Smears	\$0	20% coinsurance
Mammogram (based on age and medical history)	\$0	20% coinsurance
Well Child Visits Office visits and associated lab services provided within 5 days of visit, with certain frequency limits; immunizations	\$0	20% coinsurance
Diagnostic Procedures. X-rays & other imaging; MRIs, VRAs; all lab tests	\$0	20% coinsurance
Emergency Room	\$35/visit (waived if admitted within 24 hours.)	
Ambulance Local professional ground ambulance to nearest hospital	\$0	\$0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay the difference between the maximum allowed amount and the actual charge.
Air Ambulance Transportation to nearest acute care hospital for emergency or inpatient admission.	\$0	You pay the difference between the maximum allowed amount and the actual charge.
Maternity Care Prenatal and postnatal care in doctor's office	\$12 copay for initial visit	20% coinsurance

Lab tests, sonograms & other diagnostic procedures	\$0	20% coinsurance
Obstetrical care in hospital	\$0	20% coinsurance
Routine newborn nursery care	\$0	20% coinsurance
Obstetrical care (in birthing center)	\$0	Not covered
Hospital Services	\$0	20% coinsurance
Chemotherapy X-Ray, Radium & Radionuclide Therapy	\$0	20% coinsurance
Durable Medical Equipment For example, hospital-type bed, wheelchair, sleep apnea monitor, orthotics and prosthetics.	\$0	Not covered
Medical Supplies For example catheters, oxygen, syringes.	\$0	Institutional: 20% coinsurance when billed with other covered services Professional: Covered at in-network level
Nutritional Supplements Enteral formulas and modified solid food products	\$0	20% coinsurance
Skilled Nursing Facility Up to 60 days per calendar year	\$0	Not covered
Hospice Care Up to 365 days	\$0	Not covered
Home Health Care Up to 200 visits per calendar year (A visit equals 4 hours of care) (treatment maximums are combined for in-network and out-of-network services)	\$0	20% coinsurance, no deductible
Home Infusion Therapy	\$0	Not covered
Physical Therapy & Rehabilitation-Inpatient	\$0, for up to 30 days of in-patient service per calendar year (treatment maximums are combined for in-network and out-of-network care)	20% coinsurance , for up to 30 days of in-patient service per calendar year (treatment maximums are combined for in-network and out-of-network care)
Physical Therapy & Rehabilitation-Outpatient	\$12/visit, for up to 50 visits combined in home, office or outpatient facility per calendar year	Not covered

Occupational, Speech or Vision Therapy	\$12/visit, for up to 50 visits combined in home, office or outpatient facility per calendar year	Not covered
Cardiac Rehabilitation	\$12/outpatient visit	20% coinsurance
Mental Health Care Outpatient	\$12/office visit; \$0/outpatient facility	20% coinsurance
Mental Health Care Inpatient	\$0	20% coinsurance
Alcohol or Substance Abuse Outpatient	\$12/office visit; \$0/outpatient facility	20% coinsurance
Alcohol or Substance Abuse Inpatient	\$0	20% coinsurance



Prescription Drug Benefits provided by CVS Health

At an In-Network Pharmacy: You can receive a 30-day supply or refill of a medication through a CVS Health in-network pharmacy. The copays are:

\$5 for a **generic drug**;

20% (\$25 minimum/\$40 maximum) for a **preferred brand-name drug**;

40% (\$35 minimum/\$50 maximum) for a **non-preferred brand-name drug**;

20% (\$25 minimum/\$150 maximum) for a **preferred specialty drug**;

40% (\$35 minimum/\$150 maximum) for a **non-preferred specialty drug**.

Mail-Order: You can receive a 90-day supply via mail order or a local CVS Health pharmacy. The copays are:

\$10 for a **generic drug**;

20% (\$60 minimum/\$100 maximum) for a **preferred brand-name drug**;

40% (\$100 minimum/\$130 maximum) for a **non-preferred brand-name drug**;

20% (\$60 minimum/\$300 maximum) for a **preferred specialty drug**;

40% (\$100 minimum/\$300 maximum) for a **non-preferred specialty drug**.

At an Out-of-Network Pharmacy: You must pay the full charge and then file a claim for reimbursement with CVS Health for the difference between the pharmacy's charge and the applicable copay.

Certain limitations and exclusions may apply to some medications.

Preventive Care: Any prescription considered preventive under the Affordable Care Act will be covered in full in-network if required by that Act. For more information as to whether a particular service will be covered in full, please contact CVS Health at 1-800-896-1997.



Other Health and Welfare Benefits

Vision Care

Through Davis Vision, the Plan offers one eye exam and one pair of glasses or contact lenses from the Davis Vision Collection every 24 months. For covered children, an exam and lenses are provided every 12 months, while frames are available only every 24 months. You may have to pay more for contact lenses or frames that are not in the approved group.

For out-of-network vision services, reimbursement of up to \$100 is available every 24 months (every 12 months for exams and lenses for children). The Plan will cover the cost of annual exams for children through age 18 up to the in-network reimbursement amount.

Physical Exam & Hearing Aid Benefit

Physical Exam: If you do not go to a BlueCross provider for a physical exam, the Plan pays up to \$300 per calendar year for a physical examination.

Hearing Aid: The Plan pays up to \$1,500 in a 36-month period for a hearing aid, batteries and/or repairs.

Dental Care

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

In-network dentists have agreed to charge a negotiated fee set by Delta Dental or Administrative Services Only (ASO).

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

Orthodontia not covered.

Weekly Accident and Sickness Benefit

Administered and insured through Met Life.

Pays a weekly benefit of \$200 a week, if a non-job related disabling accident, injury or sickness keeps you from working at your regular occupation.

If disability continues, benefits can be paid up to a maximum of 26 weeks.

The weekly accident and sickness benefit is not available for covered dependents.

Life Insurance

Pays a benefit of \$20,000 if you die while you are actively enrolled in coverage (not available for covered dependents).



Eligibility

When your coverage begins

You are eligible for Plan A benefits if you work 60 days in covered employment within six consecutive months. Covered employment only includes the days for which the Fund receives a contribution from your employer on your behalf.

Your coverage starts on the first day of the second month after you complete the 60-day requirement, and it continues for six months.

For example, suppose Joanne starts to work in covered employment in February 2018 and completes 60 days between February and July 2018. Joanne's initial coverage will be for the six-month period starting September 1, 2018 and continuing through February 28, 2019.

The following table shows how this works.

IF YOU WORK 60 DAYS DURING THE MONTHS OF:	YOU MET THE ELIGIBILITY REQUIREMENT AT THE END OF:	YOUR PLAN A COVERAGE IS FOR THE SIX-MONTH PERIOD:
January – June	June	August – January
February – July	July	September – February
March - August	August	October – March
April – September	September	November – April
May – October	October	December – May
June – November	November	January – June
July – December	December	February – July
August – January	January	March – August
September – February	February	April – September
October – March	March	May - October
November – April	April	June – November
December – May	May	July - December

However, you may be eligible for benefits earlier than shown in the above chart if you complete 60 days in less than six months.

For example, suppose Pat starts to work in covered employment in February 2018 and completes 60 days by the end of April 2018. Pat's initial coverage will be for the six-month period starting June 1, 2018 and continuing through November 30, 2018.

Please note that excess days or unused days cannot be banked, stored or used in another period.

How you maintain your coverage

Your coverage under Plan A will continue as long as you work at least 60 days in covered employment over consecutive six-month periods.

For example, suppose Joanne from our example above works 60 days between February 1, 2018 and July 31, 2018. Her coverage starts on September 1, 2018, and continues for six months, until February 28, 2019. That is called her **initial coverage period**. She will lose coverage on March 1, 2019 unless she works at least 60 days in covered employment between August 1, 2018 and January 31, 2019. If she does work at least 60 days in covered employment between August 1, 2018 and January 31, 2019, she will be eligible for another six months of coverage, starting March 1, 2019.

What happens if your employer pays contributions late?

You will only receive credit toward Plan eligibility for days for which your employer is obligated to contribute to Plan A and such contributions are timely received. Most contracts require your employer to pay the Fund Office for your days worked in covered employment within 20 days of the month in which you worked. However, your employer may pay contributions late.

The Fund will not credit you with any day until the contribution due for such day is actually received. If the Fund Office receives contributions from your employer late, but **less than six months after** the actual dates worked, the Fund Office will apply these days based on the actual work dates.

If the Fund Office receives employer contributions **six months or more after** the actual dates you worked in covered employment, and your coverage was affected by the delinquent contributions, the Fund Office will credit such days prospectively, starting on the date they are received. That will be your first credited day. All remaining days that were paid late by your employer will be applied on a go forward basis with a maximum of five days per week unless reported otherwise.

If you wish to have contributions received more than six months late applied to the actual period for which you worked in covered employment, you will need to contact the Fund Office immediately to make such a request. In no event can this be granted if such contributions are received more than 12 months from the actual dates of work performed, or if the request is received more than 30 days after such contributions are received.

Please note that excess days or unused days cannot be banked, stored or used in another period.



Please note that excess days or unused days cannot be banked, stored or used in another period.



How you can enroll your spouse and/or dependents

You can enroll your eligible dependents in Plan A coverage. Eligible dependents include:

- Your spouse, if you are legally married.
- Your children, regardless of marital, financial dependency or student status, through the end of the calendar year in which they turn age 26.
- Children are your natural children, stepchildren, children required to be recognized under a Qualified Medical Child Support Order (QMCSO) and adopted children (including a proposed adopted child during a waiting period before finalization of the child's adoption.) You cannot enroll a foster child in this Plan.
- Children are covered until the December 31st of the calendar year in which they turn age 26. However, you can extend coverage for your unmarried dependent children over age 26 who are unable to do any work to support themselves because of a physical handicap or mental illness, developmental disability or mental retardation, if they have received a Social Security disability award. The incapacity must have started before the child reached age 26. You must submit initial written proof of the child's disability to the Fund Office within 31 days after the child's 26th birthday. The Fund Office may periodically ask you to provide proof that the dependent continues to be eligible for Social Security disability benefits. Coverage under this extension ends if the dependent child is no longer considered disabled, marries, is no longer dependent on you for support or becomes able to earn a living.
- **Adopted children** are covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is adopted or placed for adoption with you within 60 days after the child was born will be covered from birth, provided the Fund Office receives your request to cover the child along with a birth certificate within 60 days of the child's birth.

If you acquire a dependent after you enroll, that dependent will be covered when he or she first becomes your dependent, provided that you furnish the Fund Office with **proof of dependent status** within 60 days of the date he or she became your dependent. If you do not provide proof of dependent status on time, your dependent will be enrolled on the first of the month after you provide the Fund Office with proof of dependent status.

Proof of dependent status that you need to provide to the Fund Office

You must submit the following documents to the Fund Office as proof of your eligible dependent's status:

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

Coverage for your spouse and/or dependents will begin on the same date that your coverage starts, as long as you provide the Fund with proof of dependent status.

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

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

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

Please Note: If you do not provide timely proof of dependent status, any claims submitted to the Plan for your dependents will not be considered for payment.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. If you have a QMCSO, you must submit it to the Fund Office. The Fund Office will determine whether the order is a QMCSO as required under federal law. You or your beneficiary can receive a copy of the Plan's procedures for handling QMCSOs at no cost by contacting the Fund Office. The Plan provides benefits according to the requirements of a QMCSO. The Fund Office will notify you and any alternate recipients if a QMCSO is received.

Keep your personal information up to date

It is your responsibility to make sure that the Fund has accurate information for administering your Plan A participation. The fastest and simplest way to maintain your information is to visit us online at www.iatsenbf.org. By going to the Life Events panel, you can securely log on, upload documents and add or change your information.

You must notify the Fund Office promptly if:

- you marry
- a child is born to you, you adopt a child or acquire a stepchild, or a child is placed with you for adoption
- you change your address or phone number
- you become divorced
- a covered dependent dies
- a child reaches the maximum age for coverage or a disabled child covered beyond age 26 marries
- you want to change your beneficiary



When your coverage ends

How you can lose your coverage

If you do not work at least 60 days in covered employment over a six-month eligibility period, you will lose coverage at the end of your coverage period.

For example, suppose Pat works 60 days in covered employment between February 1, 2018 and April 30, 2018. Pat's initial coverage will be for the six-month period starting June 1, 2018 and continuing through November 30, 2018. Let's say she only works 50 days in covered employment between May 1, 2018 and October 31, 2018. Since she did not work at least 60 days over that six-month eligibility period, she will lose coverage on November 30, 2018. Pat cannot use days in excess of 60 from prior periods nor can she store her currently earned 50 days for future coverage periods.

You can also lose your coverage if the Plan terminates.

How your dependents can lose their coverage

Your dependents will lose coverage if:

- your coverage ends
- they no longer meet the definition of "dependent"
- the Plan cancels Plan A coverage for all dependents, or
- the Plan terminates.

Extended coverage for dependents upon your death: Please note that if you die at a time when you worked enough for the next coverage period, your dependents will continue to be enrolled through the end of that coverage period.

When your coverage, or coverage for any one or more of your dependents, under the Plan ends, you may be able to continue coverage by electing COBRA coverage (see page 18). The Plan also has rules for limited extensions of coverage in special situations, which are described next.

Family Medical Leave Act

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

- due to the birth, adoption or placement of a child with you for adoption
- to provide care for a spouse, child or parent who has a serious health condition, or
- for your own serious health condition, which prevents you from performing one or more essential functions of your job.
- The FMLA may also allow you to take up to 26 weeks during a 12-month period to take care of a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from serious illness or injuries as a result of his or her service.

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

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

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

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

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA (see page 18).

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

Military Leave

If you enter military service, you will be provided continuation and reinstatement rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA protects employees who leave for and return from active duty in the uniformed services (including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces and the commissioned corps of the Public Health Service). If you elect continuation coverage under USERRA, you and any eligible dependents will be covered under Plan A when your leave began (and any eligible dependents covered under Plan A when your leave began) may continue coverage for up to 24 months.

- If you are on active duty for 31 days or less, you (and eligible dependents covered under Plan A when your leave began) will continue to receive the health care coverage that you would otherwise have received under this Plan.
- If you are on active duty for more than 31 days, you can continue coverage for yourself (and eligible dependents covered under Plan A when your leave began) for up to 24 months by paying 102% of the cost of coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described next).

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

If you are called to active duty, you must notify the Fund Office in writing as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Plan on the day your leave



You may be able to extend your coverage if you leave work for specific reasons. Please check with the Fund Office if you have any questions.



started. Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

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

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

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

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

Rescission of Coverage

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

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

COBRA Continuation Coverage

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

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

- 1. "Qualified Beneficiary":** Under the law, a Qualified Beneficiary is any employee or the spouse or dependent child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
 - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
 - A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new spouse is not entitled to elect COBRA for him/herself.
- 2. "Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e. g. employee continues working even though entitled to Medicare) then COBRA is not available



If you lose coverage under the Plan, you may be able to extend your and/or your dependents' coverage by paying for COBRA continuation coverage. You will receive a notice from the Fund Office if you are eligible for COBRA continuation coverage.



Qualifying COBRA Events.

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

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

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

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

Newborn Children

If you have a newborn child, adopt a child or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 60 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

Multiple Qualifying Events

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

Notice of COBRA Eligibility

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

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

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

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

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





The notice of COBRA eligibility must include the following:

- your name
- the names of your dependents
- your Social Security number and the Social Security numbers of your dependents
- your address
- the nature and date of the occurrence you are reporting along with proof of the event
- if the event is a divorce, a copy of the divorce decree
- if you are requesting a disability extension, the name of the disabled person and a copy of the disability determination letter from the Social Security Administration
- if you are reporting a second qualifying event, the name of the qualified beneficiary(ies) and the date and proof of the second qualifying event (for example, a copy of a divorce decree).

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

Paying for COBRA Coverage

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

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

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

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

When COBRA Coverage Ends

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

- Coverage has continued for the maximum 18-, 29- or 36-month period, measured from the date coverage is lost.
- The Plan terminates. If the coverage is replaced, your coverage may continue under the new plan.
- You or your dependent(s) fail to make the necessary payments on time.
- You or your covered dependent(s) become covered under another group health plan that does not exclude coverage for preexisting conditions, or the preexisting conditions exclusion does not apply.
- You or a covered dependent becomes entitled to benefits under Medicare.
- You or your dependent(s) are continuing coverage from the 19th to 29th month of a disability, and the disability ends.

Special note

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





Hospital and Medical Benefits through Empire Blue Cross Blue Shield

Empire Blue Cross and Blue Shield offers a lot of services to help with your medical needs. You can call them or get information about their services online.

Health Management

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

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

Precertification and the Medical Management Program

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

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

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

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

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

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

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



Precertification ensures that you get the right services at the right time from the right provider. Contact Empire's Medical Management Program to precertify the services listed.

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

If Services Are Not Pre-certified

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

What You Will Need When You Call

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

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

Initial Decisions

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

PREAUTHORIZATION REVIEWS

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

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

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

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

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



CONCURRENT REVIEWS

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

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

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

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

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

RETROSPECTIVE REVIEWS

If Empire has all information necessary to make a determination regarding a retrospective claim, Empire will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If Empire needs additional information, Empire will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. Empire will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of their receipt of the information or the end of the 45-day period.

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

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

- The relevant medical information presented to Empire upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to Empire upon retrospective review existed at the time of the preauthorization but was withheld or not made available to Empire;
- Empire was not aware of the existence of such information at the time of the preauthorization review; and
- Had Empire been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.
 - If Empire's Medical Management Program does not meet the above timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

If a Request Is Denied

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See Claims and Appeals Procedures, which begins on page 97, for more information.

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

Requesting Coverage for New Medical Technology

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

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

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

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

Case Management

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

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

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

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

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

Health and Wellness Solutions

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

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

Empire's Health and Wellness Solutions is organized into:

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

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

- **24/7 NurseLine and AudioHealth Library** – receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call 1-877-Talk-2-RN (1-877-825-5276). If you need advice on comforting a baby in the middle of the night or need to locate a doctor, you can call the 24/7 NurseLine. Call the 24/7 NurseLine to:
 - Assess and understand your symptoms.
 - Find additional help to make informed healthcare decisions.
 - Locate a doctor, hospital or other practitioner.
 - Get information about an illness, medication or prescription.
 - Find information about a personal health issue such as diet, exercise or high blood pressure
 - Answer questions on pregnancy
 - Get assistance with discharge from a hospital
 - Help you decide if a medical situation requires emergency treatment.

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

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

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

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

Here's how to use 24/7 NurseLine:

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



Take advantage of all the services offered by Empire Blue Cross and Blue Shield by going to the “Members” section at www.empireblue.com.

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

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

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

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

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

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

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

Here’s how to get to “My Health”:

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



Hospital and Health Benefits

Terms You Should Know

- **Adverse determination** is a communication from Empire's Medical Management that reduces or denies benefits.
- **Annual maximum** is the maximum amount the Plan will pay for covered expenses in one calendar year.
- **Annual out-of-pocket limit** is the most you pay during a Benefit Period in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Benefits At A Glance" section for cost shares that apply to your Plan.
- **Authorized services** – See "precertified services."
- **Autism spectrum disorder (ASD)** is any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including Autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).
- **Case management** refers to assistance and support available when you or a member of your family faces a chronic or catastrophic illness or injury.
- **Clinical Trials.** The Plan will cover the routine patient costs for your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if you are:
 - Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
 - Referred by a Participating Provider who has concluded that your participation in the approved clinical trial would be appropriate.

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

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

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

- A federally funded or approved trial; or
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

- **Coinsurance** is the percentage of a covered medical expense you pay.
- **Concurrent** refers to a claim or review during treatment.
- **Conformity with Law.** Any term of this SPD which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.
- **Copayment, or Copay,** is the fee you pay for office visits and certain covered services when you use in-network providers. The Plan then pays 100% of the remaining Covered Expenses.
- **Covered services** are services for which Empire provides benefits under the terms of the Plan’s contract. For example, Empire covers one in-network annual physical exam per year. Certain frequency or other limitations may apply.
- **Deductible** is the dollar amount you must pay each calendar year before the Plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family **deductible**. Once the family deductible is met, the Plan will pay benefits for covered **out-of-network** services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit – if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.
- **Fraud and Abusive Billing.** Empire has processes to review claims before and after payment to detect fraud and abusive billing. Empire may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If Empire selects a Provider for review under this program, then as part of the review process, Empire may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan’s participants. Participants seeking services from out-of-network providers could be balance billed by the out-of-network provider for those services that are determined to be not payable due to a reasonable belief of fraud or other intentional misconduct or abusive billing.
- **Health Care Professional** means an appropriately licensed, registered or certified physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this benefit plan.
- **Hospital/facility** means, for purposes of certifying inpatient services, a hospital or facility must be a fully licensed acute-care general facility that has all of the following on its own premises:
 - A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies



- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
 - A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care
 - Assigned emergency personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
 - Diagnostic radiology facilities
 - A pathology laboratory
 - An organized medical staff of licensed doctors
 - For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.
 - For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan.
 - For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York’s. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.
 - For behavioral healthcare purposes, the definition of “hospital” may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.
 - For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with Empire.
 - Empire does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.
- **In-network benefits** are benefits for covered services delivered by in-network providers and suppliers. Services provided must fall within the scope of their individual professional licenses.
 - **In-network provider/supplier** is a doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:
 - is in Empire’s PPO network
 - is in the PPO network of another BlueCross and/or BlueShield plan, or
 - has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a PPO network.

- **Itemized bill** is a bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider's name and address and descriptions of each service, while a hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Empire identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.
- **Lifetime maximum** is the maximum amount of benefits your plan will pay for covered expenses over the course of your lifetime.
- **Maximum allowed amount** is the maximum amount the Plan reimburses for services and supplies. In-network providers have agreed to accept the maximum allowed amount as payment in full for services. Out-of-network providers may bill you for amounts above the maximum allowed amount and you will be responsible for paying any amount charged above the maximum allowed amount. For more detail on the maximum allowed amount see the section "How Much You Will Pay—Maximum Allowed Amount" on page 45.
- **Medically necessary** means services, supplies or equipment provided by a hospital or other provider of health services that are:
 - Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury,
 - In accordance with standards of good medical practice,
 - Not solely for the convenience of the patient, the family or the provider,
 - Not primarily custodial, and
 - The most appropriate level of service that can be safely provided to the patient
 - The Plan covers benefits described in this SPD as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

Empire will determine medical necessity based on a review of:

- Your medical records;
- Empire's medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.
- Services will be deemed Medically Necessary only if:
 - They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
 - They are required for the direct care and treatment or management of that condition;
 - Your condition would be adversely affected if the services were not provided;
 - They are provided in accordance with generally accepted standards of medical practice;
 - They are not primarily for the convenience of you, your family, or your provider;
 - They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;

- When setting or place of service is part of the review, services that can safely be provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office or the home setting.
- **Non-participating facility** is a hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's PPO contract, or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.
- **Out-of-network benefits** refer to the reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs.
- **Out-of-network deductible** means the amount you pay for services of out-of-network providers/suppliers before the Plan pays any benefits. Once your out-of-network deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called the **out-of-network coinsurance**, of Empire's maximum allowed amount for the out-of-network service. You are responsible for any amounts not covered, or which are in excess of the maximum allowed amount. You pay your out-of-network coinsurance up to an annual out-of-pocket limit. Once you meet your annual out-of-network out-of-pocket limit, you will not be required to pay coinsurance, but you will be responsible to pay the difference between the provider's actual charge and Empire's maximum allowed amount. This is not applied to the deductible and coinsurance amounts. Refer to the Benefits At A Glance section for your out-of-network deductible, coinsurance and out-of-pocket limit.
- **Out-of-network provider/supplier** is a doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:
 - is not in Empire's PPO network,
 - is not in the PPO network of another BlueCross and/or BlueShield plan, and
 - does not have a negotiated rate with another BlueCross and/or BlueShield plan.
- **Participating hospital/facility** is a hospital or facility that:
 - is in Empire's PPO network,
 - is in the PPO network of another BlueCross and/or BlueShield plan, or
 - has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a PPO network.
- **Precertified services** are services that **must** be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by the Plan, such as planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.
- **Provider** means a hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license. For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy. For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

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

- **Retrospective review** is one that is conducted after you receive medical services.
- **Same-day surgery** means surgery performed in a hospital or other facility that does not require an overnight stay. For same-day surgery, the definition of “hospital” may include a free-standing ambulatory surgical facility that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan. “Facility” does not include a provider’s office.
- **Treatment maximums** refers to the maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined. For example, if the plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits in-network and 13 visits out-of-network.
- **Treatment of autism spectrum disorder** is care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist.
- **Urgent precertification** is one associated with medical circumstances that require a quick decision.
- **Voluntary Clinical Quality Programs** seek to promote good health and the early detection of disease. They are designed to encourage participants to obtain certain covered Preventive Care or other recommended care covered by the Plan not received within the recommended timeframe. For instance, a program may be designed to encourage you to bring your child to his or her primary care physician for a well-child or well-baby care visit if you missed a recommended check-up, or may encourage you to get certain screening tests such as a mammogram if you have not been tested within the recommended age range. Or, a program may encourage you to have a medical visit within a specific time period such as a postpartum checkup within a set number of days after delivery of a newborn or a home visit so you can provide a blood sample for a recommended laboratory test.

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

- a gift card in the amount of \$50 or retailer coupons, such as for discounts on eye glasses; or
 - a home test kit at no cost to allow you to conveniently collect a specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. In this case, you may need to pay any cost shares that normally apply to covered laboratory tests under your benefit plan, but the home test kit will be free to you; or
 - a home visit to allow you to provide a specimen for certain covered laboratory tests, or for certain biometric screenings. In this care, you may need to pay any cost shares that normally apply to covered laboratory tests, but the home visit will be free to you.
 - If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, Empire recommends that you consult your tax advisor.
- **Eligibility.** You, your covered Spouse, and each covered Dependent can participate in the Voluntary Clinical Quality Program(s) if the targeted service applies, based on the recommended clinical guidelines the program promotes. These programs will be offered to participants who have certain conditions, who fall within certain age ranges, or who are due to receive certain recommended preventive or other care based on a recommended timeframe. For example:
 - Participants between ages 50-75 years who have not undergone colorectal cancer screening as recommended by the American Cancer Society may be eligible to participate in a program designed to encourage these members to obtain a recommended preventive colorectal cancer screening, such as a fecal occult blood screening test.

- Participants between ages 50-74 years who have not had a mammography screening as recommended by the United States Preventive Services Task Force may be eligible to participate in a program designed to encourage these members to obtain the screening through the offer of a gift card awarded upon receipt of documentation that the screening was completed.
- If you are eligible for a clinical quality program that Empire offers, Empire will contact you by phone or mail to offer you the chance to participate. You may also call us at the phone number on your ID card if you have any questions regarding program participation. We will explain to you the care you are recommended to receive and the time frame within which you need to receive it to be in eligible for the reward if applicable.

- **Rewards.** Rewards for participation in a clinical quality program and completion of the identified services within the specified timeframe include monetary rewards in the form of a gift card or retailer coupon such as for discounts on eye glasses, so long as the recipient is encouraged to use the reward for a product or service that promotes good health. In other cases, you will receive a home test kit at no cost to make it more convenient for You to receive the recommended care.

These programs are offered and administered by Empire; this Plan will not have any responsibility regarding your participant in these programs.

Plan A is a preferred provider network (PPO) that provides a comprehensive package of hospital and health care benefits for medically necessary services. The Plan offers a network of health care providers available to you through Empire BlueCross BlueShield. Health care providers include doctors, hospitals, laboratories and other medical facilities that provide health care services. Some health care providers contract with health plans like Empire to provide services to members as part of the plan's "network."





Managing Your Health Care Online

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

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

What You Need To Do

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

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

How to Reach Empire

You can use the Click-to-Talk feature to contact Empire three different ways:

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

Get Personalized Information

After you register, click on My Health from your secure homepage for the following features:

- take the Health IQ test and compare your score to others in your age group
- find out how to improve your score—and your health—online
- find out how to take action against chronic and serious illnesses
- get health information for you and your family.

Empire gives you more choices if you have customer service questions. Use the Internet, phone or mail to get the information you need, when you need it.

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit www.empireblue.com. At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially.

BY TELEPHONE

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

IN WRITING

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

Your Identification Card

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

Plan Basics

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

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

Use Your Plan to Your Best Advantage

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

- Be sure you know what is covered. That way, you and your doctor are better able to make decisions about your health care. Empire will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the Plan applies to certain types of care.
- Remember to precertify hospital, same day surgery (for medically necessary cosmetic/ reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied. Starting on page 23 for more information on precertification requirements.
- Ask questions about your health care options and coverage. To find answers, you can:
 - read this booklet
 - call Empire's Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply
 - call 24/7 NurseLine and AudioHealth Library — available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss health care options and more.

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

In-Network Services

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

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

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

Out-of-Network Services

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

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

	IN-NETWORK	OUT-OF-NETWORK
Provider's charge	\$500	\$500
Maximum allowed amount	\$400	\$400
Plan pays provider	\$388	\$320 (80% of maximum allowed amount)
You pay provider	\$12 copay	\$180 (20% of maximum allowed amount plus the \$100 above the maximum); assumes you have satisfied the deductible

How to Find an In-Network Provider

Empire's PPO network gives you access to providers throughout the country. To locate a provider in Empire's operating area, visit www.empireblue.com. You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. You can also request that Empire's PPO Directory be mailed to you free of charge by calling Member Services at 1-800-553-9603 or visit www.bcbs.com to locate participating providers.

For emergency room visits for emergency care, or emergency inpatient stays required by your medical condition, you can use any BlueCard provider and receive in-network benefits.

Inter-Plan Programs

Out-of-Area Services Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area that Empire serves, (the "Empire Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Empire Service Area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") do not contract with the Host Blue. Explained below is how Empire will pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above.

BlueCard® Program Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Empire used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs BlueCard® Program. If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Empire will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Non-Participating Providers Outside Our Service Area

Allowed Amounts and Member Liability Calculation When Covered Services are provided outside of Empire's Service Area by Non-Participating Providers, Empire may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions In certain situations, Empire may use other pricing methods, such as billed charges, the pricing Empire would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Empire makes for the Covered Services as set forth in this paragraph.

BlueCard Worldwide® Program

If you plan to travel outside the United States, call Member Services to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact Empire for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with BlueCard Worldwide In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms, You can get international claim forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

How Much the Plan Will Pay—Maximum Allowed Amount

The maximum allowed amount is the maximum amount of reimbursement the Plan will pay for services and supplies:

- that are covered services
- that are medically necessary, and
- that are provided in accordance with all applicable precertifications, Medical Management Programs or other requirements set forth in the Plan.

You will be required to pay a portion of the maximum allowed amount if you have not met your deductible, or have a copay or coinsurance. (See the Benefits at a Glance beginning on page 4 for a description of applicable copays and coinsurance.)

In addition, when you receive covered services from an out-of-network provider, you will be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

When you receive covered services from a provider, Empire will evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Empire's determination of the maximum allowed amount. Application of these rules does not mean that the covered services you received were not medically necessary. It means Empire has determined that the claim submitted was inconsistent with procedure coding rules and/or the Fund's reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same provider or other health care professional, Empire may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

In-Network and Out-of-Network Services

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

In-network services.

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

Out-of-network services

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

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

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

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

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding In-Network Providers or visit our website at www.empireblue.com.

Out-of-network services reimbursed based on in-network cost sharing (up to the maximum allowed amount) under certain circumstances

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

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

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

Emergency care:

If you obtain covered services for emergency care, as defined on page 51, even if you are unable to contact Empire before the services are rendered, Empire may authorize reimbursement to you based on the in-network cost share (deductible, copay and/or coinsurance) but only up to the maximum allowed amount. However, you will still have to pay any amount billed by the provider above the maximum allowed amount. See the examples below as to what you would have to pay in such a situation.

You had no control over the selection of an out-of-network provider:

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

Example: Plan A has no coinsurance for in-network hospital services, and 20% coinsurance for out-of-network hospital services after the out-of-network deductible has been met. You undergo a surgical procedure in an in-network hospital. The hospital has contracted with an out-of-network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The out-of-network anesthesiologist's charge for the service is \$1,200. The maximum allowed amount for the anesthesiology service is \$950. You will not be obligated to pay any coinsurance on the maximum allowed amount of \$950; the Plan pays \$950. You may receive a bill from the anesthesiologist for the difference between \$1,200 and \$950 (the amount over the maximum allowed amount). Your total out-of-pocket responsibility would be \$250 (the difference between the maximum allowed amount and the amount charged).
- You choose an in-network surgeon. The charge is \$2,500. The maximum allowed amount for the surgery is \$1,500; you have no coinsurance when an in-network surgeon is used. The Plan pays \$1,500. The in-network surgeon must accept the total of \$1,500 as payment in full.
- You choose an out-of-network surgeon. The out-of-network surgeon's charge for the service is \$2,500. The maximum allowed amount for the surgery service is \$1,500; your coinsurance for the out-of-network surgeon is 20% of \$1,500, or \$300, after the out-of-network deductible has been met. The Plan pays 80% of \$1,500, or \$1,200. In addition, the out-of-network surgeon could bill you the difference between \$2,500 and \$1,500, or \$1,000, so your total out-of-pocket charge would be \$1,300 (20% coinsurance plus the amount over the maximum allowed amount) plus any remaining deductible.

No in-network provider is available:

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

Example: You require the services of a specialist, but there is no in-network provider for that specialty in your state of residence. You contact Empire in advance of receiving any covered services, and Empire authorizes you to go to an available out-of-network provider for that covered service and agrees that the in-network cost share will apply.

- Plan A has 20% coinsurance for out-of-network providers and a \$12 copay for in-network providers for a specialist office visit. The out-of-network provider's charge for this service is \$500. The maximum allowed amount is \$200.
- Because Empire authorized the in-network cost share amount to apply in this situation, you will be responsible only for the in-network copayment of \$12 and the Plan will be responsible for the remaining \$188 of the \$200 maximum allowed amount.
- Because the out-of-network provider's charge for this service is \$500, you may receive a bill from the out-of-network provider for the difference between the \$500 charge and the maximum allowed amount of \$200. Combined with your in-network copay of \$12, your total out-of-pocket expense would be \$312.



Hospital and Medical Benefits: What Is Covered

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

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

Each of these is described in the sections that follow.

Doctor's Services

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

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



Tips For Visiting Your Doctor

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

Ask about a second opinion anytime that you are unsure about surgery or a cancer diagnosis. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist, as long as your participating doctor provides a written referral to a non-participating specialist. If you visit a non-participating specialist without a written referral, you must pay the out-of-network deductible and coinsurance.

What Is Covered

Covered services are listed in Your Benefits At A Glance section. Following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury
- Diabetes supplies prescribed by an authorized provider:
- Blood glucose monitors, including monitors for the legally blind
- Testing strips
- Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
- Oral agents for controlling blood sugar
- Other equipment and supplies required by the New York State Health Department
- Data management systems
- Diabetes self-management education and diet information, including:
- Education by a physician, certified nurse practitioner or member of their staff:
- At the time of diagnosis
- When the patient's condition changes significantly
- When medically necessary
- Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
- Home visits for education when medically necessary

- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care
- Health care forensic examinations performed in a state that mandates coverage without cost sharing will be covered at 100%

ONLINE VISITS

Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Member Access To begin the online visit, log on to www.livehealthonline.com and establish an online account by providing some basic information about you and your plan. Before you connect to a Doctor, you will be asked to identify: the kind of condition you want to discuss with the Doctor, list your local pharmacy, provide information for the credit card you want your cost share for the visit to be billed to, agree to the terms of use, and select an available Physician. If you are not in New York State when you seek an online visit, you will need to check to be sure an online Doctor is available in the state you are in because online Doctors are not available in every state.

The visit with the Physician will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access your records and print them, and may email or fax them to Your Primary Care Physician.

Note about Covered Services Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor;
- To request Preauthorization for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

What Is Not Covered

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

- screening tests done at your place of work at no cost to you
- free screening services offered by a government health department
- tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes

- orthotics for treatment of routine foot care
- routine vision care
- routine hearing exams
- hearing aids and the examination for their fitting
- services such as laboratory, x-ray and imaging and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- surgery and/or treatment for gender change that does not meet Empire's medical criteria for medical necessity
- services given by an unlicensed provider or performed outside the scope of the provider's license.

If You Need Emergency Care

Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

Emergency Services are not subject to prior authorization requirements.

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

EMERGENCY ASSISTANCE 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan. You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same co-payment as for an office visit.

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

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

TIPS FOR GETTING EMERGENCY CARE

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

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

What's Not Covered

These emergency services are not covered:

Use of the Emergency Room:

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

EMERGENCY AIR AMBULANCE

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

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

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

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





Emergency Land Ambulance

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

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

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

Non-Emergency Ambulance Transportation

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

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

Limitations/Terms of Coverage

The Plan does not cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Empire, even though prescribed by a Physician.

The Plan does not cover non-ambulance transportation such as ambulette, van or taxi cab.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

If You Have an Emergency Outside the U.S.

If you have an emergency outside of the United States and visit a hospital that participates in the BlueCard® Worldwide program, simply show your Empire ID card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

If you are having a baby

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

For out-of-network maternity services, you pay the deductible, coinsurance and any amount above the maximum allowed amount. Empire's reimbursements for the remaining balance may be consolidated in up to three installments: two payments for prenatal care, and one payment for delivery and post-natal care.

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

What Is Covered

Covered services are listed in the Benefits At A Glance section. Following are additional covered services and limitations:

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

FUTURE MOMS PROGRAM

Empire understands that having a baby is an important and exciting time in your life, so they developed the Future Moms Program. Specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. Plus, they are available to answer any questions you may have. While most pregnancies end successfully with a healthy mother and baby, Empire's Future Moms Program is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. They can also provide home health care referrals and health education counseling.

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

What Is Not Covered

These maternity care services are not covered:

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

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

Infertility Treatment

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

Following are covered services and limitations:

- Medical and surgical procedures, such as
 - artificial insemination
 - intrauterine insemination and
 - dilation and curettage (D&C), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility;

- Services in relation to diagnostic tests and procedures necessary to determine infertility, or in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:
 - hysterosalpingogram
 - hysteroscopy
 - endometrial biopsy
 - laparoscopy
 - sono-hysterogram
 - post-coital tests
 - testis biopsy
 - semen analysis
 - blood tests
 - ultrasound, and
 - other medically necessary diagnostic tests and procedures, unless excluded by law.

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

What Infertility Services Are Not Covered

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

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

If you convert to an individual policy after your coverage under Plan A ends, your new policy may not include infertility benefits.





Hospital Services

The Plan covers medically necessary care when you stay at a hospital for surgery or treatment of illness or injury. The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the Medical Management section (which begins on page 23) for additional information.

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

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

Covered Inpatient and Outpatient Care

Here is a list of hospital services covered and limitations for both inpatient and outpatient (same-day) care:

- diagnostic x-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- anesthesiologist, including one consultation before surgery and services during and after surgery
- blood and blood derivatives for emergency care, same-day surgery or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, when preapproved by Empire's Medical Management Program (your provider must call to precertify these services). You must call to precertify out-of-network MRIs/MRAs.
- PET/CAT scans and nuclear cardiology services.
- Health care forensic examinations performed in a state that mandates coverage without cost sharing will be covered at 100%

Covered Inpatient Care

The following are additional covered services for inpatient care:

- Semi-private room and board when the patient is under the care of a physician, and a hospital stay is medically necessary;
- Coverage is for unlimited days, unless otherwise specified, or if limited by precertification;
- Operating and recovery rooms;
- Special diet and nutritional services while in the hospital;
- Cardiac care unit;
- Services of a licensed physician or surgeon employed by the hospital;
- Care related to surgery;
- Use of cardiographic equipment;
- Drugs, dressings and other medically necessary supplies;
- Social, psychological and pastoral services;
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery;
- Reconstructive surgery for a functional defect which is present from birth;
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment;
- Facilities, services, supplies and equipment related to medically necessary medical care.

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

Reconstructive surgery

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the Benefits at a Glance section on pages 4-8 for applicable deductibles and coinsurance.) If you would like more information on WHCRA benefits, call your Plan Administrator at 1-212-580-9092 in New York or 1-800-456-FUND (3863) outside New York.

What Inpatient Services Are Not Covered

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

- private duty nursing
- private room. If you use a private room, you will pay the difference between its cost and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your deductible or coinsurance maximum.
- diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
- services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums or infirmaries at schools, colleges or camps
- any part of a hospital stay that is primarily custodial
- elective cosmetic surgery or any related complications
- Surgery and/or treatment for gender change that does not meet Empire's medical criteria for medical necessity
- hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility as defined in the Terms You Should Know section beginning on page 32.

Outpatient Care

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

- same-day and hospital outpatient surgical facilities
- surgeons
- surgical assistant if none is available in the hospital or facility where the surgery is performed, and the surgical assistant is not a hospital employee
- chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.

- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
 - at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis). Any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered.
 - in a hospital-based or freestanding facility.

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



What Outpatient Services Are Not Covered

Outpatient services that are not covered include, but are not limited to:

- Private duty nursing
- Services performed in the following:
 - “Nursing or convalescent homes”
 - Institutions primarily for rest or for the aged
 - Rehabilitation facilities (except for physical therapy)
 - Spas
 - Sanitariums
 - Infirmaries at schools, colleges or camps
- Elective cosmetic surgery or any related complications
- Hospital services received in clinic settings that do not meet Empire’s definition of a hospital or other covered facility. See “hospital/facility” in the Terms You Should Know section.
- same-day surgery not precertified as medically necessary by Empire’s Medical Management Program
- routine medical care including but not limited to inoculation or vaccination and drug administration or injection, excluding chemotherapy
- collection or storage of your own blood, blood products, semen or bone marrow
- surgery and/or treatment for gender change that does not meet Empire’s medical criteria for medical necessity

When You Need Hospital Care

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



Durable Medical Equipment and Supplies

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

Plan A covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from in-network suppliers only. An Empire in-network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Empire's Member Services at 1-800-553-9603. Out-of-network benefits are not available for these products.

Here is a list of covered durable medical equipment and supplies:

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

What Is Not Covered

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

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



Skilled Nursing and Hospice Care

Plan A covers inpatient care in a skilled nursing facility or hospice. Benefits are available for in-network facilities only.

Skilled Nursing Care

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

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

What Is Not Covered

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

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

To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.



Hospice Care

Plan A covers up to 365 days of hospice care. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of an in-network hospital or at home, as long as it is provided by an in-network hospice agency. Covered hospice care services include:

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

Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. For out-of-network home health care, you pay coinsurance only (the deductible does not apply.) Out-of-network agencies must be certified by New York State or have comparable certification from another state. Benefits and plan maximums are shown in the Benefits At A Glance section.

You are covered for up to 200 home health care visits per calendar year (combined in-network and out-of-network visits). A visit is defined as up to four (4) hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.

Here is a list of covered home health care services:

- part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
- part-time home health aide services (skilled nursing care)
- physical, speech or occupational therapy, if restorative
- medications, medical equipment and supplies prescribed by a doctor
- laboratory tests.
- Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

What Is Not Covered

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

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





Physical, Occupational, Speech and Vision Therapy

Plan A covers up to 30 days of *inpatient* physical therapy and rehabilitation per calendar year (in or out of network). It also covers up to 50 physical therapy and rehabilitation visits a year in your home, office or at an outpatient facility—but from in-network providers only. The Plan also covers 50 visits per calendar year for occupational, speech and vision therapy combined - but from in-network providers only.

In addition, the Plan covers up to an additional 30 visits if medically necessary in the 12 months following a surgical procedure related to the treatment of a neurological disorder. Neurological disorders may include, but are not limited to, amyotrophic lateral sclerosis, cerebral palsy, epilepsy, Parkinson's disease, muscular dystrophy, multiple sclerosis, spastic paraplegia, and Tourette's syndrome.

Physical therapy, physical medicine or rehabilitation services or any combination of these are covered up to the Plan maximums if they are prescribed by a physician, designed to improve or restore physical functioning within a reasonable period of time and approved by Empire's Medical Management Program. Outpatient care must be given at home, in a therapist's office or in an outpatient facility by an in-network provider. Inpatient therapy must be short term.

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

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

What Is Not Covered

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

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



Behavioral Health Care

Inpatient and outpatient treatment for both alcohol or substance abuse and mental health is covered both in-network and out-of-network.

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

If you do not call to precertify behavioral health care, or if you call but do not follow Empire's recommended treatment plan, benefits may be denied or reduced as described on page 23. If you do not agree with a certification decision made, you can file an appeal. See Claims and Appeals Procedures, which begins on page 97.

Covered Mental Health Care

The Plan covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges.

Covered services include:

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

As is true for any medical inpatient admission, when you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call Empire's Member Services at 1-800-553-9603 within 48 hours.



What Is Not Covered

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

- care that is not medically necessary
- out-of-network inpatient mental health care at a facility that is not an acute care general hospital.
- conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of someone under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Covered Treatment for Alcohol or Substance Abuse

You are covered for inpatient detoxification, as medically necessary. Covered services include family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the Plan may receive one counseling visit per day.

Out-of-network outpatient treatment must be provided at a facility that has New York State certification from the Office of Alcoholism and Substance Abuse Services or, if outside of New York State, is approved by the Joint Commission on the Accreditation of Health Care Organizations. The program must offer services appropriate to the patient's diagnosis.

What Is Not Covered

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

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

Autism/Applied Behavior Analysis (ABA)

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

- **Screening and Diagnosis.** The Plan will provide coverage for assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.
- **Behavioral Health Treatment.** The Plan will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed provider. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments (over the duration of the intervention) in objective and measurable terms.
- **Applied Behavior Analysis (ABA).** The Plan will provide coverage for Applied Behavior Analysis, when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst.
- **Psychiatric and Psychological Care.** The Plan will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
- **Therapeutic Care.** The Plan will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, and physical therapists to treat Autism Spectrum Disorder and when the services provided by such providers are otherwise covered under this Plan. Services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists under this Plan.
- **Assistive Communication Devices (ACDs).** The Plan will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, The Plan will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. The Plan will only cover devices that generally are not useful to a person in the absence of a communication impairment. The Plan will not cover items such as, but not limited to, laptops, desktops, or tablet computers. We will cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Plan will determine whether the device should be purchased or rented.
 - Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per covered device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

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

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



Other Services Not Covered

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

Dental Services

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

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire’s judgment are experimental or investigative, or obsolete or ineffective
- Any hospitalization in connection with experimental or investigational treatments. “Experimental” or “investigative” means that for the particular diagnosis or treatment of the covered person’s condition, the treatment is not of proven benefit or not generally recognized by the medical community (as reflected in published medical literature).
- Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person’s condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

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

However, the Plan will cover an experimental or investigational treatment approved by an External Review agent. The process for External Reviews is described on page 108 of this document.

Gene Therapy

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

Government Services

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

Home Care

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

Inappropriate Billing

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



Medically Unnecessary Services

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

Prescription Drugs

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

Travel

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

Vision Care

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

War

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

Workers' Compensation

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

Limitation as Independent Contractor.

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



Prescription Drug Benefit Through CVS Health

Terms You Should Know

- **Brand-name drug** refers to a prescription drug sold under the registered or trademarked name given to it by the drug manufacturer that holds the manufacturing and marketing rights to that drug.
- **CVS Health Mail Service Pharmacy** is the prescription drug mail service under the Plan through which you can fill your and your enrolled dependents' prescriptions for most maintenance and long-term drugs (those taken for more than 30 days).
- **Generic drug** refers to a lower-cost equivalent of a brand-name drug. It is approved by the U.S. Food and Drug Administration (FDA) and has the same active ingredients as its brand-name equivalent.

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

Formulary

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

Specialty Drugs

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



Mandatory Generic

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

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

Retail Pharmacy

You can fill a prescription at an in-network or out-of-network retail pharmacy. You will pay less if you use an in-network pharmacy—and there will be no claim forms to file.

Using an In-Network Pharmacy

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

- fill a short-term or 90-day prescription, and
- fill your prescription with a generic drug, a brand-name drug that does not have a generic equivalent or a brand-name drug that does have a generic equivalent.

UP TO A 30-DAY SUPPLY AT A CVS HEALTH NETWORK PHARMACY

Drug Type	
Generic Drug	\$5
Preferred brand-name drug	20% coinsurance (\$25 minimum/\$40 maximum)
Non-preferred brand-name drug	40% coinsurance (\$35 minimum/\$50 maximum)
Preferred specialty drug	20% coinsurance (\$25 minimum/\$150 maximum)
Non-preferred specialty drug	40% coinsurance (\$35 minimum/\$150 maximum)
Up to a 90-Day Supply at a CVS Health Pharmacy or by Mail*	
Generic drug	\$10
Preferred brand-name drug	20% coinsurance (\$60 minimum/\$100 maximum)
Non-preferred brand-name drug	40% coinsurance (\$100 minimum/\$130 maximum)
Preferred specialty drug	20% coinsurance (\$60 minimum/\$300 maximum)
Non-preferred specialty drug	40% coinsurance (\$100 minimum/\$300 maximum)

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

There is no copayment required for certain preventive care prescriptions: Prescriptions that are considered preventive care under the Affordable Care Act will be covered in full in-network and the above copay schedule will not apply. Contact CVS Health for more information as to whether a particular prescription will be covered in full.

Using a Non-Network Pharmacy

If you go to a non-network retail pharmacy, you will be required to pay the full cost of your prescription. If you file a claim for reimbursement with CVS Health at the address listed on your claim form, you will be reimbursed for the difference between the pharmacy's charge and the appropriate copay. Claim forms are available from the Fund Office and on the Web site. Prescription claims must be filed within 365 days of the date the prescription was filled.

Mandatory Mail Service

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

Mail Service Pharmacy

The CVS Health Mail Service Pharmacy is designed for filling prescriptions for maintenance medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes or asthma. When you fill prescriptions through the Mail Service Pharmacy, you can elect delivery either to your home or an alternate address.

The Mail Service Pharmacy offers both convenience and savings. When you use the Mail Service, you pay two times the amount you would pay at a retail pharmacy and receive up to three times the amount. Your copay for a 90-day supply depends on whether you fill your prescription with a generic drug, a preferred brand-name, or a non-preferred brand-name drug.

DRUG TYPE	WHAT YOU PAY
Generic drug	\$10
Preferred brand-name drug	20% coinsurance (\$60 minimum/\$100 maximum)
Non-preferred brand-name drug	40% coinsurance (\$100 minimum/\$130 maximum)
Preferred specialty drug	20% coinsurance (\$60 minimum/\$300 maximum)
Non-preferred specialty drug	40% coinsurance (\$100 minimum/\$300 maximum)

Filling Your Initial Prescription through the Mail Service Pharmacy

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

- First, get a 90-day prescription from your doctor with up to as many as three refills (if appropriate).



You can get your maintenance medications either by mail, or pick them up at a CVS pharmacy.



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

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

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

Refilling Prescriptions

You can refill prescriptions by phone, online or at a local CVS Health pharmacy. To reach CVS Health's automated refill phone service, call 1-800-896-1997. To order prescriptions online, you need to register at www.caremark.com. As a registered user, you can also check on the status of your order, look up the cost of your prescription drugs, view your prescription history, find a local in-network pharmacy and contact a pharmacist.

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

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

What Is Covered

The Plan covers the following:

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

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

What Is Not Covered

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

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



Vision Care Benefits Through Davis Vision

Vision care benefits help to pay for routine eye examinations, frames and lenses for you and your covered dependents.

What Is Covered

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

Exams

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

Lenses

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

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

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

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

Frames

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

Contact Lenses

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

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

Mail Order Contact Lenses

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



Low vision services

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

Receiving Services from an In-Network Provider

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

If You Use an Out-of-Network Provider

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

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

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

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

What Is Not Covered

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

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

May I use the benefit at different times?

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

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

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

Member Service Representatives are available:

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

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



Dental Benefits



To find a Delta Dental PPO dentist or a Delta Dental Premier® dentist, call 1-800-932-0783 or log on to deltadentalins.com/iatse.

Dental benefits are provided through Delta Dental and include comprehensive coverage.

If you live in New York State, you may choose dental coverage through Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS) instead of Delta Dental. For more information about ASO/SIDS coverage, call ASO/SIDS at 1-800-537-1238.

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

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

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

Eligible Expenses

In order to qualify for reimbursement, an expense must:

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

How Much You Will Pay

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

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

Example

Here is a comparison of how much you would pay a PPO dentist, a Premier dentist and an out-of-network dentist for a crown that costs \$2,000 unreduced.

	DELTA DENTAL PPO	DELTA DENTAL PREMIER	OUT-OF-NETWORK
Fee for procedure (crown)	\$2,000	\$2,000	\$2,000
Amount approved by Delta Dental	\$745	\$1,450	N/A, Delta may approve the procedure as being medically necessary, but there is no discounted amount
How much the Plan pays (from Schedule of Dental Benefits)	\$400	\$400	\$400
How much you pay	\$345 (\$745-\$400)	\$1,050 (\$1,450-\$400)	\$1,600 (\$2,000-\$400)

What Is Covered

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

In general, the Plan covers the following diagnostic and preventive services:

- oral examination, twice per calendar year
- prophylaxis (teeth cleaning), twice per calendar year
- x-rays, subject to annual x-ray maximum
- fluoride treatment for children (up to age 19), twice per calendar year
- sealant for children (up to age 19), for posterior permanent teeth, maximum of one treatment per tooth
- amalgam and composite fillings

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

Orthodontic services are not covered under the Plan.

Predetermination of Benefits

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

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

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

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

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

Alternate Procedures.

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

What Is Not Covered

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

The plan does not provide benefits for:

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



**Questions? Contact
Delta Dental
Member Services at
1-800-932-0783 or
log on to
[deltadentalins.com/
iatse](http://deltadentalins.com/iatse).**

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

Limitations

Benefits to enrollees are limited as follows:

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

The following expenses are not covered under the Plan:

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

Filing a Claim for Dental Benefits

Both Delta Dental PPO and Premier dentists submit claims for payment to Delta Dental.

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

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



Benefits for Physical Exams and Hearing Aids

Two additional health care benefits are provided under Plan A.

Out-of-Network Physical Exam

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

Hearing Aid

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

Claiming the benefits

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



Weekly Accident and Sickness Benefit Through MetLife

What The Benefit Is

The weekly benefit is \$200 per week.

When Payments Start And End

Benefits begin as of the first day of a disability due to an accident and as of the fourth day of a disability due to an illness. (However, if you're hospitalized due to either accident or illness, your benefits start as of the first day of hospitalization, if that is earlier than the date that would otherwise apply.)

Payments continue for as long as you remain disabled, up to 26 weeks.

Successive periods of disability.

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

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

Make sure your beneficiary designations are up to date



Exclusions

The group policy does not cover any disability caused by, contributed to by, or resulting from:

- Your loss of professional license, occupational license or certification;
- Intentionally self-inflicted injuries;
- War, whether declared or undeclared, or act of war, insurrection or terrorist act;
- Active participation in a riot;
- Commission of, or attempt to commit, a felony;
- Attempted suicide;
- Occupational sickness or injury. However, disability due to occupational sickness or injury for Partners, Professional Corporation (P.C.) Partners, owners-employees, or Sole-Proprietors and/or S-Corporation Shareholders that cannot be covered by Worker's Compensation law, occupational disease law or similar law will be covered.



Life Insurance Benefit Through MetLife

A life insurance benefit, provided through MetLife, pays a lump sum to your survivors in the event of your death, from any cause, while you are covered under Plan A.

If you die while enrolled in Plan A, your designated beneficiary or beneficiaries will receive a \$20,000 life insurance benefit.

Naming a Beneficiary

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

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

- If two (2) or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.
- If there is no designated beneficiary, or if no designated beneficiary is living after the insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters (including half-siblings). If no class has a survivor, the beneficiary is your estate.
- When a beneficiary dies before you, that person's interest in your life insurance benefit automatically ends.
- If beneficiary or a payee is a minor or incompetent to receive payment, payment will be made to that person's guardian.
- You may change your beneficiary designation at any time by completing a new beneficiary designation form (available online at www.iatsenbf.org) and sending it to the Fund Office. The change will be effective when the Fund Office receives the new form. You do not need anyone's consent to change your beneficiary designation.
- Designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Fund Office will not be effective.



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

Consider your beneficiary designations and coverage elections under all your benefit plans if you have a change in family status, such as a marriage, separation, divorce, death or the birth or adoption of a child.

Filing a claim for benefits

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

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



Retiree Health Benefit Plan

Terms You Should Know

- **Year of service** is a calendar year in which you were covered under the Health & Welfare Fund for at least six consecutive months.

While Plan A coverage generally stops once you no longer meet the active eligibility requirements described on page 11, if you meet the requirements for retiree coverage, you will be entitled to the special retiree benefits from the Retiree Health Benefit Plan described in this section.

Eligibility

You are entitled to retiree benefits if:

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

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

Enrollment

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

If you return to work for an employer that contributes to the IATSE National Health & Welfare Fund and you work at least 60 days in covered employment in a period of six consecutive months, or receive contributions to Plan C equal to at least the charge for one quarter of Plan C-4 single coverage (see the Plan C summary plan description for details), your retiree health benefits will be suspended. They can begin again only after you stop working. Please call the Fund Office if you return to work and/or need an application.

What the Benefit Is

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

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

Spouse Coverage

Your spouse is also entitled to these benefits if he or she is on Medicare. (The Fund Office will require a copy of the Medicare card as proof of coverage.) If you die after your retiree coverage begins, your spouse’s coverage will continue for one year. If your spouse dies or you divorce and you remarry, your new spouse will be eligible for coverage, provided that you enroll the new spouse with the Fund.

Medicare Benefits

Medicare consists of four parts:

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

Applying for Medicare

Be sure to contact the Social Security Administration at least three months before you reach age 65 to sign up for both Medicare and Social Security benefits. You can file your application by telephone by calling 1-800 MEDICARE (1-800-633-4227) or in person at a local Social Security office. For more information or to find an office near you, visit www.medicare.gov.

How to Claim Benefits

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

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

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

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

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

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

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

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

Continuation of Benefits

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





Coordination of Benefits

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

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

Other Group Medical Plans

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

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

Which Plan Pays First

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

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

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

If this hospital/medical plan is secondary, Empire will reduce the benefits paid by this Plan so the total benefits paid by both plans will not be greater than the maximum allowed amount. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

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

Medicare

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

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



Claims & Appeals Procedures

Terms You Should Know

- **Adverse determination** (i) a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; (ii) a reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or (iii) a rescission of coverage, whether or not there is an adverse effect on any particular benefit.
- **Days:** For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.
- **A health care professional**, for the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

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

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

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;

- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.
- A request is not a claim if it is:
 - Not made in accordance with the Plan's benefit claims filing procedures described in this section;
 - Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
 - Made by a person who will not identify himself or herself (anonymous);
 - A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
 - A request for prior approval where prior approval is not required by the Plan;
 - A general eligibility inquiry. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
 - The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
 - A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

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

Where to File Claims

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

Send completed hospital claims to:

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

Send completed medical claims to:

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

Here are important tips about filing claims:

- File the claim within 18 months of the date of service.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

Prescription Drug Benefits

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

Vision Care Benefits

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

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

Dental Benefits

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

For Delta Dental, send the completed form to:

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

For ASO/SIDS, send the completed form to:

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

Physical Exam or Hearing Aid Benefits

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

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

Weekly Accident and Sickness Benefit

Contact Met Life at:

Met Life
Call: 888-444-1433
Fax: 1-800-230-9531

Life Insurance Benefits or Eligibility

Contact the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092 in New York
1-800-456-FUND (3863) outside New York

Retiree Health Plan Benefits

Contact the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092 in New York
1-800-456-FUND (3863) outside New York

When Claims Must Be Filed

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

For weekly accident and sickness benefits, the completed claim form (including the required documentation described in the form) should be sent to MetLife within 20 days of the disabling accident or injury or onset of the disabling illness. If it is submitted after 20 days, MetLife will not invalidate a claim if the claim was sent in as soon as it is reasonably possible.

Authorized Representatives

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

Claims Procedures

The claims procedures for hospital, medical, dental, vision, prescription drug, physical exam and hearing aid benefits and medical reimbursement will vary depending on whether you are making a preservice claim, an urgent care claim, a concurrent care claim or a post service claim. The procedures for life insurance claims also vary. Empire's procedures are described beginning on page 97. The procedures for other providers are described below.

Preservice and Urgent Care Claims

A preservice claim is a claim for a benefit that requires approval (in whole or in part) before medical care is obtained.

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

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

If an extension is needed because the health organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The health organization then has 15 days (from the date it receives your response) to make a decision and notify you of the determination. You have the right to appeal a denial of your pre-service claim. (See External Review and Timing of Notice of Decision on pages 108 and 109).

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

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

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

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

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

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

Concurrent Claims

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

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

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

Postservice Claims

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

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

If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

Weekly Accident and Sickness Benefit Claims

A weekly accident and sickness benefit is a claim for weekly income due to a disabling accident, injury or illness off the job. To file a weekly accident and sickness benefit claim, you must complete a claim form, available on the Fund's website, www.iatsenbf.org, or upon request from the Fund Office, 212-580-9092; 1-800-346-FUND (3863). Please complete the claim form and follow the steps below for submission:

The completed claim form (including the required documentation described in the form) should be sent to MetLife within 20 days of the disabling accident or injury or onset of the disabling illness. If it is submitted after 20 days, MetLife will not invalidate a claim if the claim was sent in as soon as it is reasonably possible.

Once you are receiving a weekly accident and sickness benefit, MetLife may also require proof as often as reasonably required to verify the continuation of the disability.

MetLife will make a decision on the claim and notify you of the decision within 45 days. If MetLife requires an extension of time due to matters beyond its control, MetLife will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time MetLife notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided MetLife notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which it expects to render a decision. If an extension is needed because MetLife needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). Once you respond to MetLife's request for the information, you will be notified of its decision on the claim within 30 days.

Life Insurance Claims

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

Once the Fund Office receives the claim and forwards it to MetLife, MetLife will notify the beneficiary that the claim has been received and is being reviewed. The beneficiary will be instructed to call the MetLife Group Claims Department at 800-638-6420, option 2, for any questions.

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

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

Eligibility Claims

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

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

Dental Claims

If a post-service claim is denied in whole or in part, Delta Dental shall notify you and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fifteen (15) days, for processing. If there is an extension, you and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either you or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. You or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which your response is received by the Plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

Notice of Decision

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

- the identity of the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal [or external review]);
- a description of the Plan’s standard, if any, that was used in denying the claim;
- reference(s) to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary;
- a description of the appeal procedures and applicable time limits about how to initiate an internal and an external appeal; and
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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

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

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

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

Request for Review of Denied Claim

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

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

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

Empire BlueCross and BlueShield

1407 Church Street Station
New York, NY 10008-1407
Attention: Appeal Department

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

Review Process

The review process works as follows:

- You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office or health organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the benefit determination); it demonstrates compliance with the Fund Office's or health organization's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.
- You will have the opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits.
- You have the right to a full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office or health organization on your claim, without regard to whether their advice was relied upon in deciding your claim.

- The review will not afford deference to the initial adverse benefit determination. Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will be neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
- You will also be provided free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on review is denied based on a new or additional rationale, you will receive the rationale, free of charge. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Timing of Notice of Decision on Appeal

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

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

Urgent Care Claims. The Fund and the individual health organizations will decide urgent care appeals within 72 hours of their receipt. You will receive verbal notice of the decision, followed by written notification.

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

Postservice Medical, Hospital, Prescription Drug, Dental and Vision Claims

Empire BlueCross BlueShield, CVS Health, Delta Dental, ASO/SIDS and Davis Vision offer two levels of appeal for postservice claims. Each level of appeal will be decided within 30 days. If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be filed within 180 days of your receipt of the decision regarding the first appeal. All decisions will be in writing. You must exhaust both levels of review in order to be eligible for External Review. See the External Review section on page 109 for more information.

Dental Claims

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

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

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

If you or your attending dentist believe the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the Enrollee or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Weekly Accident and Sickness Benefit Claims

Appeals of denials of weekly accident and sickness benefit claims must be mailed to MetLife for review. MetLife will decide your appeal and notify you in writing within 45 days of its receipt of your request for review. In special circumstances, an extension of time, not exceeding 45 days, may be required. If an extension is required, MetLife will notify you in writing before the initial 45-day period expires of the special circumstances and the date when a decision will be made.

Life Insurance Claims

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

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

Eligibility, Physical Exam, Hearing Aid, and Retiree Health Benefits Claims

Appeals related to eligibility, the physical exam or hearing aid benefit, or retiree health benefits are directed to the Board of Trustees of the Fund, which will provide one level of appeal. Ordinarily, decisions on appeals involving such 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 decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will include:

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

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

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

External Review

If the outcome of the mandatory two levels of appeal is adverse to you, you will be eligible for an independent External Review pursuant to federal law if you meet all the following requirements:

- you were covered by the Fund at the time the health care item or service was requested or, for a retrospective review, were covered by the Fund at the time the item or service was provided
- the denial of the claim involved medical judgment or relates to a rescission of coverage
- you have exhausted the Fund's internal appeal process, or are not required to exhaust (for example you are appealing an urgent care claim), and
- you have timely provided all of the information and forms required to process an External Review.

Please note that life insurance claims, weekly accident and sickness benefits, eligibility claims and any other denial based on a determination that you are not eligible under the Plan are not subject to External Review.



When to request External Review

You must submit your request for External Review within four months of the notice that your claim was denied after the second level of review. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the health organization's decision, can be sent between the health organization and you by telephone, facsimile or other similar method.

How to request External Review

A request for External Review must be in writing unless the applicable health organization determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for the review of your claim denial. However, you are encouraged to submit any additional information that you think is important for review.

How to request an Expedited External Review

To proceed with an Expedited External Review, you or your authorized representative must contact the health organization that denied your claim on review and provide at least the following information:

- the identity of the claimant
- the date(s) of the medical service
- the specific medical condition or symptom
- the provider's name
- the service or supply for which approval of benefits was sought
- any reasons why the appeal should be processed on a more expedited basis.

If you qualify for an Expedited External Review, you do not need to first request an internal review from the entity that denied the claim.

There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through ERISA. For more information, please contact the entity that provided the service.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which medical or dental services were provided or the Fund rendered its final decision on eligibility.



Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses sustained by you or your eligible dependents, and you or your eligible dependents have a right to a recovery or have received a recovery from any source. A recovery includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you or your eligible dependents receive as a recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on behalf of you or your eligible dependents from any party responsible for compensating you or your eligible dependents for illnesses or injuries. The following provisions apply:

- The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you or your eligible dependents are fully compensated, and regardless of whether the payments you or your eligible dependents receive make you or your eligible dependents whole for your losses, illnesses and/or injuries.
- You or your eligible dependents and any legal representative of you or your eligible dependents must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your eligible dependents or legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you or your eligible dependents, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your or your eligible dependents' claim, attorney fees, other expenses or costs. The Plan does not recognize the "Make Whole" Doctrine.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you or your eligible dependents incur without the Plan's prior written consent. The Plan expressly rejects the "Common Fund" Doctrine. Accordingly, the "Common Fund" doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you or your eligible dependents obtain a recovery and the Plan has not been repaid for the benefits the Plan paid on behalf of you or your eligible dependents, the Plan shall have a right to be repaid from the recovery in the amount of the benefits paid on behalf of you or your eligible dependents, and the following provisions will apply:

- You or your eligible dependents must promptly reimburse the Plan from any recovery to the extent of benefits the Plan paid on behalf of you or your eligible dependents regardless of whether the payments you receive make you whole for your or your eligible dependents' losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your or your eligible dependents' recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You or your eligible dependents and any legal representative of you or your eligible dependents must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon receipt of the recovery. You or your eligible dependents must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "Common Fund" Doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- If you or your eligible dependents fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your or your eligible dependents' recovery, whichever is less, from any future benefit under the Plan if:
 - the amount the Plan paid on your or your eligible dependents' behalf is not repaid or otherwise recovered by the Plan, or
 - you or your eligible dependents fail to cooperate.
- In the event that you or your eligible dependents fail to disclose to the Plan the amount of any settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your or your eligible dependents' recovery, whichever is less, directly from the providers to whom the Plan has made payments on your or your eligible dependents' behalf. In such a circumstance, it may then be your obligation to pay the provider the full-billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.
- The Plan does not recognize the "Make Whole" Doctrine and, therefore, is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or your eligible dependents or make you or your eligible dependents whole.

Your Duties

- You or your eligible dependents must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you or your eligible dependents occurred and all information regarding the parties involved.
- You or your eligible dependents must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your eligible dependents or any legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You or your eligible dependents must not do anything to prejudice the Plan's rights.
- You or your eligible dependents must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you or your eligible dependents.
- You or your eligible dependents must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on behalf of you or your eligible dependents.

The Board of Trustees has sole discretion to interpret the terms of the subrogation and reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent or other representative shall be subject to this provision. Likewise, if the covered person's relatives, heirs and/or assignees make any recovery because of injuries sustained by the covered person, that recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.





The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Terms You Should Know

- **Plan Administrator/Sponsor** is the person who has certain authority concerning the Plan, such as Plan management, including deciding questions of eligibility for participation, and/or the administration of Plan assets. The Board of Trustees is the Plan Administrator.

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the IATSE National Health & Welfare Fund, that provide health benefits, protect the privacy of your personal health information. (These rules do not apply to the life insurance provided under our Plan.) A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is distributed to new Plan enrollees and is available from the Fund Office. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Your "protected health information" is information about you, including demographic information, that:

- is created or received by the Plan, your health care provider or a health care clearinghouse (and is not related to your non-health benefits under the Fund, e.g., disability)
- relates to your past, present or future physical or mental condition
- relates to the provision of health care to you
- relates to the past, present or future payment for the provision of health care to you
- identifies you in some manner.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan (except for any information that is received in connection with the life insurance benefit) is referred to below as "protected health information," or "PHI." The Board of Trustees agrees to the following rules in connection with your PHI:

Generally the Plan will require that you sign a valid authorization form (available from the Fund Office or the applicable Claims Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

- The Board of Trustees understands that the Plan will only disclose health information to the Board of Trustees for the Trustees' use in Plan administration functions.
- Unless it has your written permission, the Board of Trustees will only use or disclose PHI for Plan administration, or as otherwise permitted by this Summary Plan Description, or as required by law.
- Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO). Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.
- The Board of Trustees will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.
- The Board of Trustees will not use or disclose your PHI for any employment-related actions or decisions, or with respect to any other pension or other benefit plan sponsored by the Board of Trustees without your specific written permission.
- The Board of Trustees will report to the Plan's Privacy Officer if the Trustees become aware of any use or disclosure of PHI that is inconsistent with the provisions set forth in this Summary Plan Description.
- The Board of Trustees will allow you, through the Plan, to inspect and photocopy your PHI, to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will make available PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA.





- The Board of Trustees will keep a written record of certain types of disclosures it may make of PHI, so that it may make available the information required for the Plan to provide an accounting of certain types of disclosures of PHI. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.
- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:
 - Executive Director
 - all department directors
 - Health & Welfare Fund staff
 - other staff as needed for their jobs.
- These employees will be permitted to have access to and use the PHI only to perform the Plan administration functions that the Board of Trustees provides for the Plan.
- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the participants whose privacy has been violated.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.
- The Board of Trustees will return to the Plan or destroy all your PHI received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

There are also some special rules under HIPAA related to “electronic health information.” Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

The Board of Trustees has taken additional steps with respect to the implementation

of security measures for electronic protected health information, as follows:

- The Board of Trustees has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health Plan.
- The Board of Trustees has ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures.
- The Board of Trustees has ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- The Board of Trustees will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The Board of Trustees will comply with any other requirements that the Secretary to the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or guidance pursuant to HIPAA.





Genetic Information “Non-Discrimination Act” (GINA)

Effective for plan years beginning on or after May 21, 2009, GINA prohibits discrimination by group health plans such as the Plan against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Plan is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Plan.



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

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- **Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.**
- **Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.**

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

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

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



Other Information You Should Know

Board of Trustees

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

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents
- process and approve or deny benefit claims
- determine the standard of proof required in any case.

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

The Board of Trustees also reserves the right in its sole and absolute discretion to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan's termination (which might occur if the Union and the employers negotiate the discontinuance of

contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Fund assets have been disbursed. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and IATSE representatives.

Collective Bargaining Agreement and Contributing Employers

The Fund is established and maintained in accordance with one or more collective bargaining agreements. A copy of any such agreement(s) may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

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

Recovery of Overpayments

If for any reason benefit payments are made to any person from the Fund in excess of the amount which is due and payable for any reason (including, without limitation, mistake of fact or law, reliance on any false or fraudulent statements, information or proof submitted by a participant, or a participant's failure to timely inform the Fund of relevant information, such as a divorce), the Trustees (or the Plan Administrator or any other designee duly authorized by the Trustees) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest and costs). That authority shall include, but not be limited to:

- the right to reduce benefits payable in the future to the person who received the overpayment
- the right to reduce benefits payable to a surviving spouse or other beneficiary who is, or may become, entitled to receive payments under the Plan following the death of that person, and/or
- the right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and costs) against the person who received the overpayment, or such person's estate.

Assignment of Plan Benefits

Except as otherwise specifically set forth elsewhere in this Plan, authorized by the Plan in writing or required by law, any attempt to assign benefits or rights (including, without limitation, rights to sue) under this Plan are prohibited, whether or not the Plan has made any benefits payments to any third parties. Any purported assignment of benefits shall be void. Any purported assignee of benefits shall acquire no rights by reason of any such purported assignment.



Plan Information

Official Plan Name	I.A.T.S.E. National Health & Welfare Fund
Employer Identification Number (EIN)	23-7333434
Plan Number	501
Plan Year	January 1–December 31
Type of Plan	An employee welfare benefit plan that provides medical, prescription drug, vision, dental, weekly accident and sickness, and life insurance benefits
Effective Date	This Summary contains the rules in effect as of June 1, 2020.
Funding of Benefits	<p>The benefits described in this booklet are provided through employer contributions.</p> <p>The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of contribution. The Fund Office will provide participants and beneficiaries, upon written request and as required by law, information as to whether a particular employer is contributing to the Fund on behalf of its employees.</p> <p>Currently, medical benefits, hospitalization, prescription drug, dental, physical exam, hearing aid and medical reimbursement benefits are self-funded, which means they are paid directly out of Fund assets, rather than through an insurance policy. In most cases, the Fund has contracted with outside providers to administer these benefits. Life insurance and weekly accident and sickness benefits are insured through the Metropolitan Life Insurance Company ("MetLife"). Vision benefits are insured through Davis Vision.</p>
Trust Fund	All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses. The Fund's assets are invested in various investment options and are deposited or invested with banks according to guidelines and objectives adopted by the Board of Trustees.

Plan Sponsor & Administrator

The IATSE National Health & Welfare Fund is sponsored and administered by a joint Board of Trustees composed of Union trustees and employer trustees. Employer trustees are selected by the employer associations. Union trustees are designated by the IATSE. The names and addresses of the Trustees appear in this booklet. They may be contacted at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092
1-800-456-FUND (3863)

Participating Employers

The IATSE National Health & Welfare Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Plan on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and union locals sponsoring the Plan may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.

Agent for Service of Legal Process

In the event of a legal dispute involving the Plan, legal documents may be served on:

Anne J. Zeisler, Executive Director
IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204

Legal process may also be served on any individual Trustee at the Fund Office address. For disputes arising under those portions of the Plan insured by MetLife or Davis Vision, service of legal processes may be made upon the applicable insurer at one of their local offices or upon the official of the Insurance Department in the state in which you reside.



Administration and Contact Information

BENEFIT	ADMINISTRATOR/INSURER	TYPE OF FUNDING
<p>HOSPITAL AND HEALTH</p>	<p>Empire BlueCross BlueShield PPO Member Services P.O. Box 1407</p> <p>Church Street Station New York, NY 10008-1407 1-800-553-9603 1-800-241-6894 (TDD for hearing impaired) 8:30 am to 5 pm weekdays www.empireblue.com</p> <p>BlueCard® PPO Program 1-800-810-BLUE (2583) 24/7 www.bcbs.com</p> <p>Medical Management Program 1-800-982-8089 8:30 am to 5 pm weekdays 24/7 NurseLine and AudioHealth</p> <p>Library 1-877-TALK-2RN (825-5276) 24/7</p> <p>Fraud Hotline 1-800-I-C FRAUD (423-7283) 9 am to 5 pm weekdays</p> <p>Triple-S, Inc. Box 363628 San Juan, PR 00936-3628</p>	<p>Self-funded. The Fund pays the cost of benefits, which are administered by Empire BlueCross BlueShield.</p>
<p>PRESCRIPTION DRUG</p>	<p>CVS Health Health Claims Department</p> <p>See claim form for address 1-800-929-2524</p> <p>CVS Health Mail Service Pharmacy P.O. Box 2110 Pittsburgh, PA 15230-2110 www.caremark.com</p>	<p>Self-funded. Fund pays cost of benefits, which are administered by CVS Health.</p>

Administration and Contact Information (continued)

BENEFIT	ADMINISTRATOR/INSURER	TYPE OF FUNDING
VISION CARE	<p>Davis Vision Capital Region Health Park, Suite 301 711 Troy-Schenectady Road Latham, NY 12110 1-800-999-5431 www.davisvision.com</p> <p>Lens 1-2-3* 1-800-LENS-123 (536-7123) www.Lens123.com</p>	<p>The Fund pays premiums to Davis Vision, and Davis Vision provides coverage.</p>
DENTAL	<p>Delta Dental One Delta Drive Mechanicsburg, PA 17055-6999 1-800-932-0783 www.deltadentalins.com/iatse</p> <p>ASO/SIDS P.O. Box 9005, Dept. 7 Lynbrook, NY 11563-9005 1-800-537-1238 www.asonet.com</p>	<p>Self-funded. Fund pays cost of benefits, which are administered by Delta Dental and ASO/SIDS.</p>
PHYSICAL EXAMS AND HEARING AIDS	<p>ASO/SIDS P.O. Box 9005, Dept. 7 Lynbrook, NY 11563-9005 1-516-396-5525 (NY) 1-877-390-5845 (outside NY)</p>	<p>Self-funded. Fund pays cost of benefits, which are administered under a contract with ASO/SIDS.</p>
LIFE INSURANCE and WEEKLY ACCIDENT AND SICKNESS	<p>Metropolitan Life Insurance Company (MetLife)</p> <p>Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Phone: 1-800-638-6420, then press 2 Fax: 570-558-8645</p>	<p>Insured. Fund pays premiums to Met Life to provide coverage.</p>
RETIREE HEALTH BENEFIT PLAN	<p>National Health & Welfare Fund 417 Fifth Avenue, 3rd Floor New York, NY 10016-2204 1-212-580-9092 1-800-456-FUND (3863)</p>	<p>Self-funded. Fund pays cost of benefits.</p>

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