SUMMARY PLAN DESCRIPTION

PLUMBING INDUSTRY BOARD - PLUMBERS LOCAL UNION

158-29 GEORGE MEANY BOULEVARD, HOWARD BEACH, NEW YORK 11414

2005
To All Eligible Employees:

This booklet describes the benefits provided by the Plumbers Local Union No. 1 Welfare Fund (As amended through December 31, 2004) as well as information that must be included to comply with the Employees Retirement Income Security Act of 1974 (ERISA). The Welfare Fund is a defined benefit Plan that provides hospital, major medical, prescription drug, dental and optical benefits for you and your dependents.

As in the past, you are not required to make any payment toward the cost of the program, which is financed by employer contributions as a result of the collective bargaining agreement between Plumbers Local Union No. 1, and your employer. However, if you lose eligibility for benefits, you may elect to continue your eligibility through the Continuation Coverage Plan. This booklet outlines the eligibility rules, describes the conditions governing the payment of benefits, and explains the procedures you should follow in filing a claim as well as an appeal procedure should your claim be denied.

We urge you to study this booklet and make full use of the coverage to which you are entitled, but we also call on you to protect your benefits. In these days of escalating medical costs it is important to assure that benefit funds are neither wasted nor misused, so benefits can be available to safeguard the health and security of members and their families.

If you have any questions concerning the Fund’s benefits or your eligibility to participate, please call the Fund Office, Welfare Department at (718) 835-2700.

Sincerely,
Plumbers Local Union No.1 Welfare Fund

The Board of Trustees
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WHO CAN BECOME ELIGIBLE

Eligibility for benefits from the Plumbers Local Union No. 1 Welfare Fund is based upon hours worked under Collective Bargaining Agreements which obligate employers to report and pay contributions to this Fund on behalf of Employees. An Employee must satisfy certain eligibility requirements described on pages 1-6 of this Plan Booklet.

In this Plan Booklet we use different terms to refer to categories of Employees who are affected by Plan rules. These terms and some other related terms are explained below:

An Employee is an individual who is covered by a Collective Bargaining Agreement or a Participation Agreement that requires his or her Employer to make contributions to this Fund on his or her behalf. Contributions on an Employee’s behalf are made for hours worked in accordance with the applicable Agreement.

A Collective Bargaining Agreement is an agreement between an Employer and Plumbers Local Union No. 1 that requires the Employer to make contributions to this Fund. A Participation Agreement is an agreement between the Trustees of this Fund and an Employer.

Work under a Collective Bargaining Agreement or Participation Agreement for which contributions must be paid to this Fund is called Covered Employment.

An Eligible Employee is an Employee who has satisfied the requirements for eligibility for benefits from this Fund as described in this Plan Booklet and who is currently eligible for benefits.

An Active Eligible Employee is an Employee whose eligibility for benefits is based on hours worked for which his or her Employer must make contributions. Therefore, Employees who are eligible under the Plan based completely on payment of COBRA premiums and Employees who are eligible because hours are credited during periods of disability are Eligible Employees but are not Active Eligible Employees.

A Retired Employee is an Employee who has qualified for and is receiving Retiree Benefits from this Plan. An Employee is a Retired Employee on the effective date of his Pension.

Initial Eligibility for Employees

An Employee\(^1\) will be eligible for benefits from this Plan as an Active Eligible Employee on the first day of the calendar month following three (3) consecutive months of Covered Employment with contributing Employers in which the Employee is credited with at least 270 hours in Covered Employment under this Plan or the Prior Plans. The Prior Plans are the health and welfare plans of former Local Unions 1, 2, and 371, which were merged to form this Plan on June 1, 1998.

\(^1\) Employees and their Dependents who were eligible for benefits from the Prior Plans on May 31, 1998 were Eligible Employees and Eligible Dependents for benefits from this Plan effective June 1, 1998.
Probationary employees are not covered by this Plan. Hours worked by an Apprentice or Helper prior to becoming a second grade Apprentice or a second term Helper for an Employer (Probationary Period) are not credited for purposes of Eligibility in this Plan.

Individual Employee contributions to gain or continue eligibility are not allowed. In certain circumstances, however, you may pay COBRA premiums or make a self-payment to purchase continued health coverage. These special circumstances are described in the Section entitled Continuation Coverage.

This Fund also has reciprocal agreements with certain other welfare funds of U.A. Local Unions. Eligibility can be continued for an employee who provides the Fund Office with documentation of hours worked in Covered Employment for a delinquent Employer or employer outside of the Plumbers Local Union No. 1 jurisdiction. When contributions are received or verified by this Fund from a reciprocal fund, no less than the actual hours worked will be credited for eligibility purposes under this Fund. If a reciprocal fund makes contributions at a rate that is greater than this Fund’s contribution rate, additional prorated hours will be credited. Contributions made to this Fund, which are forwarded to a reciprocal fund, will not be counted for eligibility purposes in any way by this Fund.

Eligibility is based on payroll reports, with monthly cut-off dates determined by each Employer. Contribution reports with hours worked are not due and processed until late in the following month. The Fund Office, therefore, cannot certify in advance when benefits will start or end. Notices are sent as soon as eligibility can be determined.

All Employees should keep track of the hours they work each month. The Fund Office can advise an Employee of eligibility status if the Employee has a record of hours worked. Generally, an employee who is working for a delinquent Employer will be credited with up to 35 hours per week for each week that he or she is employed by a delinquent Employer, for purposes of continued eligibility in this Fund following the end of the delinquent employment either upon the Employee’s return to Covered Employment or under the Unemployment Extension, if applicable. Proof in the form of pay stubs or reports submitted directly from the Employer indicating work hours must be submitted to the Fund Office. However, hours will not be credited after the date on which Plumbers Local Union No.1 directs Employees to leave employment with the delinquent Employer.

Termination of Eligibility for Employees

An Active Eligible Employee and his or her Eligible Dependents will lose eligibility for benefits on the last day of the sixth month following the most recent period of three consecutive months in which the Employee works at least 270 hours in Covered Employment. This period described above is called the Eligibility Period.

An Employee who loses eligibility and who is willing and able to work in Covered Employment may be eligible for the Unemployment Extension of Coverage described on page 4.
Continuing Eligibility During Family and Medical Leave

The Family and Medical Leave Act of 1993 (FMLA) entitles Employee's eligible under the Act to take up to 12 weeks of unpaid, job-protected leave each year for the Employee’s own illness, or to care for a seriously ill child, spouse or parent. In addition, the FMLA provides leave for the birth of a child of the Employee or placement of a child with the Employee in the case of adoption or foster care. Employees eligible for leave under the FMLA are those who have been employed at least 12 months by an Employer and who have provided at least 1,250 hours of service to the Employer. An Employee at a work site in which there are less than 50 Employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75 mile radius of that Employee equals or is greater than 50.

Employers covered by the FMLA are required to maintain medical coverage for Employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the employee had continued to work. This means that an Employer is required to continue making contributions to the Fund on behalf of Employees while they are on FMLA leave. Employees should contact the Fund Office if they are planning to take FMLA leave so that the Fund is aware of the Employer’s responsibility to report and contribute during the FMLA leave. However, any dispute between the Employee and the Employer concerning the application of FMLA to the Employee’s leave or the obligation of the Employer, must be resolved between the Employee and Employer. Employees with questions about the FMLA should contact their Employer or the nearest office of Wage and Hours Division, listed in most telephone directories under U.S. Government, Department of Labor, and Employment Standards Administration.

Extension of Eligibility During Periods of Temporary Disability

An Active Eligible Employee who is Temporarily Disabled and who is receiving State Disability Benefits or Workers Compensation Benefits continues to be eligible under this Fund for up to thirty (30) months from the date eligibility would otherwise terminate. However the extension cannot exceed 50% of the period the Employee was eligible for benefits from this Fund or a Prior Plan (of Local 1, 2 or 371) measured immediately preceding the date of disability. See page 82 for Subrogation.

A Temporarily Disabled Employee, including an Employee who is receiving State Disability Benefits, Workers’ Compensation Benefits, or is disabled and not receiving State Disability Benefits, or Workers’ Compensation Benefits will be covered at the same Level of Benefits for which he or she was eligible immediately before becoming Temporarily Disabled.

A Temporarily Disabled Employee must provide the details of the illness or injury including a description of the illness or injury and when it occurred, proof of State Disability Benefits or a Workers’ Compensation claim number. When an Employee receives Temporary Disability Benefits for an extended period of time, the Plan may require the Employee to submit a C-4 Medical Report (or similar document) to the Plan supporting the Employee's entitlement to continued coverage. The Employee must notify the Plan of the receipt of State Disability Benefits or Workers’ Compensation Benefits within one year from the date eligibility would otherwise terminate.
If the Employee’s eligibility is extended, he or she must provide a notarized statement each month that he or she is disabled along with proof of disability such as an affidavit documenting the disability. This statement must be submitted to the Fund Office by the 20th of each month following the month for which the notarized statement is given. In the event the Employee returns to Covered Employment, the Employee must notify the Fund and provide proof of Covered Employment.

The Trustees may terminate an Employee’s Temporary Disability Extension if the Employee fails to submit monthly proof of the continued receipt of State Disability Benefits or Workers Compensation benefits, if he or she fails to submit the monthly notarized statement, or if the Employee fails to submit additional information requested by the Plan.

The Trustees may require the Employee to appear before the Trustees or a Committee of the Trustees. The Trustees may require the Employee to submit additional evidence of his or her disability status. The Trustees may also require the Employee to be evaluated by an Independent Medical Examination periodically during the period of extended coverage. The Trustees may rely on the Independent Medical Examination in order to determine whether or not to continue the extension of coverage. The Trustees may terminate the Employee’s Workers Compensation Extension of Coverage if the result of the Independent Medical Examination indicates that the Employee is not disabled. The Trustees may also terminate the Employee’s Temporary Disability Extension if he or she fails to appear before the Trustees or Committee when requested, if he or she fails to submit additional information requested by the Trustees, if he or she presents false information to the Trustees or fails to provide relevant information, or if he or she returns to work.

**Extension of Eligibility During Periods of Unemployment**

This benefit is available during periods for which the Union certifies there is unemployment in the jurisdiction of Local Union No.1. An otherwise Eligible Employee whose eligibility terminates under the rules of this Plan because of unemployment may apply for an Unemployment Extension within one year from the date eligibility would otherwise terminate. Generally, the Employee can continue to be eligible under this Fund for up to eighteen (18) months from the date of termination. However the extension cannot exceed 50% of the period the Employee was eligible for benefits from this Fund or a prior Plan (of Local 1, 2 or 371) measured immediately preceding the date of unemployment.

The Employee must submit a request in writing and present evidence that he or she is unemployed and collecting or has collected or is unable to collect unemployment benefits during the eligibility period. If his or her eligibility is extended, he or she must provide a notarized statement each month that he or she is not working, or has been working in Covered Employment and is laid off again within the month, and is ready, willing and able to work in Covered Employment, or has returned to Covered Employment. This statement must be submitted to the Fund Office in person by the 20th of each month following the month for which the notarized statement is given. However, if the Employee returns to Covered Employment the statement can be submitted by mail.
For purposes of continued eligibility in this Fund during the Unemployment Extension, the Employee will be credited on a monthly basis for up to eighteen (18) months from the date eligibility would otherwise terminate, when the Employee provides proof described above.

An employee represented by Local Union No. 1 who is referred by the Local Union and employed as a provisional employee by the city, state or federal government during periods of unemployment will not be covered by this Plan while employed as a provisional employee. The Employee can continue to be eligible under this Plan while employed as a provisional employee. The Employee can continue to be eligible under this Plan while employed as a provisional employee. The extension cannot exceed 50% of the period the Employee was eligible for benefits from this Plan or a prior Plan (of Local 1, 2 or 371) measured immediately preceding the provisional employment, as described above.

The Trustees may require the Employee to appear before the Trustees or a Committee of the Trustees. The Trustees may require the Employee to submit additional evidence of his or her unemployed status and his or her efforts to find work including tax returns. The Trustees may terminate the Employee’s Unemployment Extension if he or she fails to submit in person the monthly notarized statement, if he or she fails to appear before the Trustees or Committee when requested, if he or she fails to submit additional information requested by the Trustees, if he or she presents false information to the Trustees or fails to provide relevant information, if he or she returns to work or if he or she refuses work offered to him or her. Eligibility for this benefit is available as long as the Union certifies that there is unemployment in the jurisdiction of Local Union No. 1.

Reinstatement of Eligibility for Employees

An Employee whose eligibility has terminated may become eligible again by satisfying the Initial Eligibility requirements on page 1. A Retired Employee who returns to work must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements on page 1.

Termination of Eligibility During Service in the Armed Forces

If an Employee enters the Uniformed Services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination for more than thirty (30) days, coverage for the Employee and his or her Dependents will terminate immediately. If the Employee is honorably discharged from the Uniformed Services, Plan coverage for the Employee and his or her Dependents will be reinstated on the day the Employee begins work in Covered Employment, provided:

- The cumulative length of the absence and all previous absences for uniformed service must not be longer than five years;
- The Employee or Employee’s representative gives advance notice to the Employer of the impending uniformed service, unless notice is precluded by military necessity;
The Employee begins work in Covered Employment within 90 days from the date of his or her discharge. If the Employee does not begin work in Covered Employment within 90 days from the date of discharge, the Employee will be required to meet the Initial Eligibility rules on page 2; and

If the absence is more than 30 days, the Employee must furnish any available documents requested by the Employer to establish his or her entitlement to the protections of USERRA.

Effective January 1, 2003, the Plan was amended to provide continuous eligibility through December 31, 2005 for a covered Employee who enters the Uniformed Services and provides the Fund Office with proof. The coverage for the Employee from this Fund will be secondary to any coverage provided as a result of the Employee’s service in the military. For dependents the Fund coverage will be primary.

**ELIGIBILITY FOR DEPENDENTS**

Once an Employee becomes eligible for benefits, certain of his or her Dependents may also become eligible for benefits from this Fund. Eligible Dependents include:

- The Employee’s Spouse to whom he or she is legally married. The Plan does not cover a former Spouse. See below for notification requirements upon change of marital status.

- The Employee’s unmarried Dependent Child(ren) until the end of the calendar year in which the child reaches age 19. A child, who marries, divorces and returns to live with the Employee while still under age 19 does not qualify for coverage as a Dependent Child.

- An Employee’s unmarried child(ren) over age 19 who is incapable of self-support due to a physical or mental disability, who became disabled prior to age 19. The child must remain continuously disabled, unmarried, incapable of self-support and financially dependent on the Employee. A Disabled Dependent Child remains eligible only so long as the Employee is eligible. The Employee must provide the Fund Office with medical evidence of the child’s disability within 45 days of the child’s 19th birthday and annually thereafter.

- An Employee’s unmarried Dependent Child(ren) over age 19 who is enrolled as a full-time student in an accredited school, college or trade school, until the earlier of the end of the calendar year in which the child is no longer a full time student or reaches age 23. Whether or not a child is a full time student is determined by the requirements of educational institution in which the child is enrolled. Therefore, the Employee must submit an original letter from the school’s bursar’s office verifying full-time student status each semester without request by the Fund Office. In the case of a trade school, the Employee must submit evidence that the child is enrolled in a full schedule for that program. Contact the Fund Office for information concerning the timing of the full-time student certification. A Dependent Child who loses his or her status as an Eligible Dependent under the Plan because he or she is not enrolled as a full time student, can again become an Eligible Dependent if
he or she reenrolls as a full time student before age 23 and submits certification of enrollment to the Fund Office.

- The Newborn Child of an Employee’s unmarried dependent, living with the Employee, limited to 30 days from date of birth unless adopted by or in the process of being adopted by the Employee.

Each Eligible Dependent must be listed on an Enrollment Form signed by the Employee and filed with the Fund Office. Each change in Dependent Enrollment (adding or terminating a Dependent) after the initial enrollment must be submitted with evidence or proof of Dependent status satisfactory to the Trustees. If there is a change in the Employee’s marital status, such as divorce or legal separation, the Employee is responsible for notifying the Fund Office immediately. Any benefits paid on behalf of a divorced Spouse or stepchild who no longer lives with the Employee after the date specified in the legal document is the responsibility of the Employee or the former Spouse.

The Term “Dependent Child” or “Dependent Children” means:

- An Employee’s own or legally adopted child(ren) including a child(ren) placed with the Employee for adoption if they rely on the Employee for maintenance and support;

- Children of the Employee’s current Spouse living with the Employee;

- Children of the Employee covered by a Qualified Medical Child Support Order (QMCSO), see page 8.

An individual will not be considered a Dependent Child if it appears that the primary purpose of the child’s living arrangement with the Employee is to obtain coverage from this Plan. Grandchildren of Employees are excluded from coverage by the Plan unless that child is placed for adoption or has been adopted by the Employee except as noted above.

**Dependent Eligibility Following Death of Employee**

Dependents who are eligible for benefits at the time of the death of the Eligible Employee continue to be covered by the Plan at no cost for six (6) months following the date of death of the Employee. Thereafter, Dependents may elect to purchase COBRA Continuation Coverage for 30 additional months until 36 months from the date of the Employee’s death, see page 13.

The Spouse of a deceased Eligible Employee may continue to purchase Plan coverage after the 36 months of COBRA Continuation Coverage until the Spouse becomes eligible for Medicare or until the Spouse remarries, if earlier.
Termination of Dependent Coverage

Benefits for Dependents end on the earliest of the following:

- The date the Employee’s eligibility terminates (see page 2);
- For the Employee’s Spouse and any step-children, the date the Employee and Spouse are divorced;
- The date a step-child is no longer living with the Employee (unless he or she is a full-time student living at school);
- The date that a Dependent Child under age 19 (or 23 if a full-time student) marries. A Dependent Child who marries cannot regain Dependent coverage;
- Six months after the date of death of an Active Eligible Employee;
- The date a Dependent becomes an Active Eligible Employee under this Plan;
- On the last day of the calendar year in which a Dependent Child is no longer a Dependent because of attaining age 19 (or age 23 if a full-time student); or
- Upon the Dependent’s entry into military service.

An Employee may not remove a Dependent who continues to qualify as a Dependent under the Plan. However, a Dependent may be removed based on a Court Order.

The Fund Office may investigate the status of any Dependent. The Fund Office may require copies of court orders, property settlement agreements, birth certificates, paternity determinations, guardianship orders, adoption papers, tax returns or any other documents or information related to the determination of an individual’s status as a Dependent.

Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs require health plans to recognize State court orders, which the Plan determines to be Qualified Medical Child Support Orders as defined by federal law. A QMCSO requires the Plan to provide coverage to an Eligible Employee’s Child even if the Employee does not have custody of the child.

A QMCSO is a judgment, decree or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree or order. To be a QMCSO, a judgment, decree or order must require the child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support. The order must include:

- the name and last known mailing address (if any) of the Employee and the names and mailing address of each child covered by the order,
- a reasonable description of the type of coverage to be provided by the Plan,
the period of coverage to which the order pertains, and

the name of the Plan.

Such an order is not qualified if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan will notify, in writing, the Eligible Employee and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the Eligible Employee and each affected child in writing of its determination as to whether an order is a Qualified Medical Child Support Order. Employees and their Dependents can obtain a copy of the procedures without charge from the Plan Administrator.

COMMUNICATION WITH CUSTODIAN OF CHILD

Upon request, Welfare Fund correspondence will be sent directly to the person having custody of the Employee’s dependent child, if other than the Employee.
ELIGIBILITY FOR RETIRED EMPLOYEES

Special Eligibility Rule for Retired Employees Covered by Prior Plans on May 31, 1998:

Retired Employees and their Dependents who were eligible for Retiree Benefits from one of the Prior Plans on May 31, 1998 and who have remained retired will be Eligible Retirees and Eligible Dependents for benefits from this Plan, effective June 1, 1998. If a Retired Employee returns to any employment before electing retiree coverage from this Plan, the individual may not elect Retiree Coverage.

Retirees for whom there is no record that they were eligible for Retiree Benefits from one of the Prior Plans on May 31, 1998 must furnish the Fund with proof that they were eligible at the time of retirement from the Prior Plan, and meet the following requirements:

- **Service** - One of the Prior Plans covered the Employee for at least 36 months of the 60 months immediately preceding retirement. For this purpose periods of self-payment and periods on the Local 2 Referral List between October 1, 1994 through June 30, 1997 will be treated as covered periods; and

- **Age** - The Employee was at least 60 when he or she initially retired or became totally and permanently disabled before age 60 as demonstrated by receipt of a Social Security Disability Award. In the case of a disabled Retired Employee, the Employee is eligible for Retiree Benefits from this Plan so long as he or she is disabled and until he or she is Medicare eligible at which time coverage will continue under the Medicare Wrap-Around Program provided by the Plan; and

- **Other** - The Employee maintains coverage for Part B, if eligible under Medicare, by self-paying the Part B premium. **NOTE**: Failure to elect Medicare Part B coverage will result in a reduction of benefits.


If the Retired Employee would have been eligible for coverage under this Special Rule, then the Surviving Spouse of the Retired Employee will be eligible. The Surviving Spouse must furnish the Fund with records to demonstrate that the Retired Employee was eligible as described above. The Spouse must also furnish records to prove that he/she was the Spouse at the time the Retired Employee was eligible and that the Spouse has not remarried.
Eligibility Rule Effective June 1, 1998:

Employees who initially retire on or after June 1, 1998 and who are receiving a pension from either the Local 1B Pension Fund, the Local 2 Pension Fund, the Local 371 Pension Fund or the Plumbers and Pipefitters National Pension Fund will be eligible for Retiree Benefits from this Plan provided that they meet the following requirements:

- **Service** - One of the Prior Plans and/or this Plan covered the Employee for at least 36 months of the 60 months immediately preceding retirement. For this purpose periods of self-payment and periods on the Local 2 Referral List between October 1, 1994 through June 30, 1997 will be treated as covered periods; and

- **Age** - The Employee was at least 60 when he or she initially retired or became totally and permanently disabled before age 60 as demonstrated by receipt of a Social Security Disability Award. In the case of a disabled Retired Employee, the Employee is eligible for Retiree Benefits from this Plan so long as he or she is disabled and until he or she is Medicare eligible at which time coverage will continue under the Medicare Wrap-Around Program provided by the Plan; and

- The Employee must elect Retiree coverage at the time of retirement.

**NOTE** – If eligible under Medicare for maximum benefits the Employee should maintain coverage for Part B, by self-paying the Medicare Part B premium. **Failure to elect Medicare Part B coverage will result in a reduction of benefits.** Once Medicare eligible a retired Employee and his or her Eligible Dependents will lose active eligibility and acquire retiree Medicare Wrap Around benefits upon the Employee’s 65th birthday, or earlier if the Employee is disabled. The Plan’s eligibility rule (Active Eligible Employee and his Eligible Dependents will lose eligibility for benefits on the last day of the sixth month following the most recent period of three consecutive months in which the Employee works at least 270 hours in Covered Employment) does not apply.

Retired Employees who meet the requirements described above are not required to make the Plan’s self-payments for Retiree Benefits. However, if an Employee retires before age 60 and elects Retiree Continuation Coverage he or she will be required to pay the COBRA rate in effect at the time. The Plan’s rules concerning eligibility for and the cost of Retiree Benefits and relation to COBRA Coverage are summarized as follows:

An employee who retires before age 60 under a “Contingent Early Retirement Pension-Awaiting Social Security Award” from the National Pension Fund will be required to pay the COBRA rate in effect at the time. However, if the Social Security Disability Award is granted, the Employee’s eligibility for Retiree benefits and payments is in accordance with the rules for Employees who initially retire on or after June 1, 1998.”

The Plan’s Retiree Continuation Coverage is available to Retired Employees from age 55 until age 65. If you meet the eligibility requirements of the Plan, at age 65, the Plan's benefits coordinate with Medicare. This is called the Medicare Wrap Around Program. See page 55.
An Employee who retires before age 60 is not eligible for the Plan's Medicare Wrap Around Program or any other coverage from the Plan at age 65 or after. Such an Employee is not eligible for COBRA Continuation Coverage upon reaching age 65 (unless the Employee is within the 18 month COBRA period measured from the date of retirement.)

An Employee who retires at age 60 or greater, or at any age in the case of Total and Permanent Disability and meets the eligibility requirements of the Plan, will be eligible for coverage from the Plan at no cost until age 65 at which time the Employee will be covered by the Plan's Medicare Wrap Around Program.

An Employee who is eligible for benefits from the Plan based on the receipt of Workers Compensation Benefits will have coverage continued through the Plan as described on page 3 of the SPD whether or not the Employee has elected to begin receipt of a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Fund. If the Social Security Disability Award is granted, the Employee qualifies for retiree coverage. If the Social Security Disability Award is denied, the Employee's eligibility for Retiree benefits and payments is in accordance with the rules for Employees who initially retire on or after June 1, 1998.

<table>
<thead>
<tr>
<th>Early Retirement Age (Inclusive)</th>
<th>Can Receive Retiree Benefits</th>
<th>Pays the following % of the COBRA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Age 60</td>
<td>Ages 55 thru 64</td>
<td>65%</td>
</tr>
<tr>
<td>Age 60 or greater</td>
<td>Ages 60 to 65 then Medicare Wrap Around Program</td>
<td>No Payment Required (Effective June 1, 1998)</td>
</tr>
<tr>
<td>Total &amp; Permanent Disability Retirement at any Age</td>
<td>Date of Disability Retirement to Medicare eligibility then Medicare Wrap Around Program</td>
<td>No Payment Required</td>
</tr>
</tbody>
</table>

**Termination of Retiree Benefits**

A Retired Employee’s benefits terminate upon his or her death or if the Retired Employee stops receiving pension benefits or returns to work in the Plumbing and Pipe Fitting Industry. A Retired Employee who returns to work must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements on page 1.
**COBRA CONTINUATION COVERAGE**

In certain circumstances in which coverage for benefits from this Plan would otherwise end due to certain events called “Qualifying Events”, an Employee or Dependent can pay to continue benefits for a limited period. This extended coverage is called COBRA Continuation Coverage and is available to both Employees and Dependents who are covered by this Plan on the day before the Qualifying Event for example, the termination of employment – that cause loss of Plan coverage. COBRA Continuation Coverage is also available to a child who is born or a child under age 18 who is placed for adoption with an Employee while the Employee is receiving COBRA Continuation Coverage.

You are responsible for paying the full cost of this coverage once all your coverage under this Plan ends. The COBRA rates are established by the Trustees and can change from time to time. COBRA Coverage does not include life insurance and weekly disability benefits.

**COBRA Rules for Employees**

An Employee may choose COBRA Continuation Coverage for himself or herself and/or for the Employee’s Spouse and/or for the Employee’s Dependent children. Coverage can be continued for up to 18 months from the date the Employee would lose coverage under the Plan because the Employee terminates employment covered by this Plan (for reasons other than gross misconduct) or because the Employee does not have sufficient hours of Covered Employment for which contributions are received by the Fund to continue eligibility.

Under certain circumstances a disabled person and his or her family may extend coverage for a total of 29 months following termination of employment or a reduction in hours of employment at an additional premium. To qualify for the additional 11 months of coverage the disabled person must have a determination of disability from the Social Security Administration. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage for this extension to apply. The determination from the Social Security Administration must be filed with the Plan within the later of 60 days of the date of the Social Security Disability determination or the date of the Qualifying Event or the date the disabled person would lose coverage under the Plan or the date the individual is informed of the notice requirement and procedure for the COBRA disability extension. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members. See “Where to Send Notices and Information in Connection with COBRA Continuation Coverage” on page 15.

If individuals receive extended COBRA Continuation Coverage because of a disability, the disabled person must also notify the Plan within 30 days of a final determination by the Social Security Administration that the person is no longer disabled, or, if later, within 30 days of the date the individual is informed of this notice requirement and procedure. COBRA Continuation Coverage ends if Medicare Coverage begins before the 29-month period expires or if the disabled person recovers from the disability and has already received 18 months of COBRA Continuation Coverage.
COBRA Rules for Dependents
If an Employee chooses not to purchase COBRA Continuation Coverage, the Employee’s Spouse and/or Dependent children can separately purchase COBRA Continuation Coverage for themselves by making the election and the required monthly premium payments. The COBRA Continuation Coverage for Dependents can be continued for up to 18 months (29 months if there is a disabled person electing coverage) if coverage would otherwise end because of the termination of the Employee’s Covered Employment or a reduction in the Employee’s hours of Covered Employment. However, coverage can be continued for up to 36 months for the Employee’s Spouse and Dependent children if their coverage would otherwise end because of:

- the death of the Employee
- the divorce or legal separation of the Employee and Spouse
- a child’s loss of status as a Dependent under the Plan (See page 6)
- the Employee becomes entitled to Medicare after the date of the qualifying event.

If an Employee’s family experiences another Qualifying Event while receiving COBRA Continuation Coverage, the Spouse and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of 36 months. This extension is available to the Employee’s Spouse and dependent children if the Employee dies or becomes entitled to Medicare (Part A, Part B, or both); or if the Employee and Spouse get divorced or legally separated or if the Employee’s dependent child stops being eligible under the Plan as a dependent child, but ONLY if the event would have caused the Spouse or dependent child to lose coverage under the Plan if the first Qualifying Event had not occurred.

Notification Requirements for COBRA Continuation Coverage
An Employee, Spouse or Dependent child must notify the Plan in writing within 60 days of a divorce, legal separation or a child’s loss of Dependent status under the Plan. An Employee’s dependents should also notify the Plan in writing within 60 days of the Employee’s death. An Employer must notify the Plan within 60 days of an Employee’s death or eligibility for Social Security benefits. The Plan will determine when an Employee’s eligibility for benefits would end due to termination of Covered Employment or reduction in hours of employment for which contributions are received by the Fund. See “Where to Send Notices and Information in Connection with COBRA Continuation Coverage” on page 15.

Following receipt of a notice, or after an Employee’s loss of eligibility due to termination of Covered Employment or reduction in hours of employment for which contributions are received by the Fund is determined; the Plan will notify Employees and their Dependents of their rights to purchase COBRA Continuation Coverage and the cost of the coverage.
Election of COBRA Continuation Coverage
The Employee and each of the Employee’s dependents have an independent right to elect COBRA Continuation Coverage. To elect COBRA Continuation Coverage, an Employee and/or Spouse and/or Dependent child must complete an election form provided by the Fund Office and submit it to the Fund Office within 60 days after the later of the date coverage would otherwise end or the date the Employee, Spouse or Dependent child receives the notice of the right to elect COBRA Continuation Coverage. See “Where to Send Notices and Information in Connection with COBRA Continuation Coverage” on page 15.

Termination of COBRA Continuation Coverage
COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- All health benefits provided by the Plan terminate;
- An Employee, Spouse or Dependent child who has elected COBRA Continuation Coverage does not make the required payments to the Fund on time;
- An Employee becomes covered under Medicare after the date of the Qualifying Event; or
- An Employee, Spouse or Dependent child becomes covered by another group health plan after the date of the Qualifying Event unless that replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to the Employee, Spouse or Dependent after coverage under this Plan is taken into account.

Where to Send Notices and Information in Connection with COBRA Continuation Coverage
Notices and information concerning COBRA Continuation Coverage should be sent to:

Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
Phone (718) 835-2700

Questions concerning your COBRA Continuation Coverage rights should also be addressed to the contact named above.

Keep Your Plan Informed of Address Changes
In order to protect your family’s rights, you should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.
Certificates of Creditable Coverage

If you or your eligible Dependents lose health coverage under the Plan, the Fund will issue you a Certificate of Creditable Coverage showing how long you were covered under the Plan. Also, you or your eligible Dependents may request the Fund to provide you with a Certificate at any time while you are covered under the Plan and within 24 months of losing coverage.

You will receive the Certificate automatically if you or your eligible Dependents:

- lose coverage under the Plan;
- become entitled to COBRA Continuation Coverage; and
- when COBRA Continuation Coverage ceases.

The Certificate provides evidence of any prior health care coverage under the Plan. You may need to furnish this Certificate if you or your Dependents become eligible under a group health plan or insurance policy that excludes certain medical conditions that existed prior to enrollment in the new plan. This Certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the six month period prior to enrollment in the new plan.
DESCRIPTION OF BENEFITS FOR ACTIVE EMPLOYEES

PROVIDER NETWORKS

The Plan has agreements with several Preferred Provider Organizations (PPOs). A PPO is a network of Participating Providers (hospitals, physicians, laboratories and radiological facilities) who have agreed to charge Eligible Employees and Eligible Dependents a preferred or negotiated rate. The Fund has these agreements with PPOs to help control medical costs.

Through the PPO Networks you will continue to have freedom of choice regarding where to seek medical care. However, if you use a Participating Provider that is in a PPO Network, your out-of-pocket expense will be less than if you use a non-participating provider, and in some circumstances, you will not have any out-of-pocket expenses. In most cases, a small co-payment at the time of the visit is all that you will have to pay. (Any co-payments made to providers are not reimbursable through the Medical Benefits provisions of the Plan.)

Services by Non-Participating Providers

The Trustees have agreed, under specific limited circumstances, that the Plan will cover services received from a non-participating provider as if the services were performed by a Participating Provider. Those services are:

- Fees for services by a non-participating Physician in connection with an Emergency Room visit covered by the Plan under the Emergency Room Benefit.
- Fees for services by a non-participating anesthesiologist when the services are provided in a participating Hospital, by a participating surgeon.

How to Choose a Network; Enrollment

Enrollment information must be provided for all Employees and Dependents including Medicare eligible Employees and Dependents. Employees must notify the Fund Office in writing to enroll a Dependent. The Fund can only enroll those Dependents of whom the Fund Office has knowledge. If you do not notify the Fund Office of a Dependent, the Dependent cannot be enrolled.

All Employees are required to provide the enrollment information required by the Fund. If you do not have a required document (for example, a marriage certificate or birth certificate), you should contact the Department of Vital Statistics of the state involved. If you are unable to obtain a copy of the record after contacting the applicable Department of Vital Statistics, you should contact the Fund Office concerning alternative ways to document the required information.
If you do not provide the required enrollment information after notice by the Fund, the Fund may suspend payments on behalf of you and/or your Dependents for whom documentation is missing until documentation satisfactory to the Trustees has been provided.

When you become eligible, you will be given the option to enroll with either PPO Network. You may change your choice of Network each year during an open enrollment period which will be held in October of each year effective the following January 1. You will be permitted to change your enrollment outside of the open enrollment period if it is necessitated by some change in circumstances such as a move of your primary residence or access to network services. However you must apply for approval to change enrollment outside of the open enrollment period. You should explain the reasons that require a change in enrollment and provide supporting documents (if applicable).

The following are the Networks with which the Plan has arrangements. A listing of medical providers participating in each of the networks will be furnished automatically without charge as a separate document. Please contact the Fund Office for information about the various Networks.

**Hospital and Physician Networks**

- **Empire Blue Cross/Blue Shield** Physicians and Hospitals
- **Group Health, Inc. (GHI)** Physicians and Hospitals

Each Preferred Provider Organizations (PPOs) offers a network of healthcare providers available to you through that PPO. Both networks include doctors, hospitals, laboratories and other medical facilities that provide healthcare services. With both PPO’s, when you need healthcare services, you have a choice. Depending on the healthcare services you need, you are free to get healthcare from providers who participate in your PPO or you can choose to use outside providers. You are covered for medically necessary services under the terms of the Plan no matter which you choose. Choosing to receive health care services from a participating provider will help you make the most of your health plan coverage and limit your out of pocket expenses. However, if you choose to use non-participating providers you will be responsible for an annual deductible and coinsurance, plus any amount above the allowed amount and you will need to file a claim to be reimbursed by your PPO.

**Be sure to present your Identification Card whenever you receive any services at a Hospital.**

**Other Preferred Provider Networks**

- **Caremark (formerly AdvancePCS)** Prescription Benefits
- **Dental Delivery Services, Inc. (DDS)** Dental Benefits
- **Vision Screening** Vision Benefits

The names, addresses and phone numbers of all of the Preferred Provider Networks with which the Plan has arrangements are listed on pages 90-91.
SUMMARY OF BENEFITS FOR ACTIVE EMPLOYEES

The key to using your PPO plan is understanding how benefits are paid. Start by choosing in-network or out-of-network services any time you need healthcare. Your choice determines the level of benefits you will receive. You can view and print up-to-date information about your Medical Benefits and Hospital Benefits by visiting www.empireblue.com or www.ghi.com, or request that information be mailed to you.

Use your PPO to your best advantage. Your health is valuable. Knowing how to use your PPO to your best advantage will help ensure that you receive high quality healthcare – with maximum benefits.

Choosing In-Network or Out-of-Network Services

In-Network services are services provided by a doctor, hospital, or ancillary provider that has been selected by the PPO to provide care to enrolled members. When you choose in-network care, you get these advantages:

- You can choose any participating provider from your PPO in New York State or the national network of your PPO.
- You do not need a referral to see a specialist, so you direct your care.
- Benefits are paid after a small co-payment for the office visit and many other services.
- Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- Usually there is no claim form to file.

Out-of-Network services are healthcare services provided by a licensed provider outside of your PPO network. For most covered 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 are responsible for an annual deductible and coinsurance, plus any amount above the allowed amount (the maximum the PPO will pay for covered service).
- You will usually have to pay the provider when you receive care.
- You will need to file a claim form to be reimbursed by the PPO.
- For doctor, hospital or healthcare facility services received from outside providers, the benefits paid are subject to an annual deductible.
- After the deductible, the Plan pays 80% of the first $5,000 per member or $12,500 per family of eligible expenses per calendar year and the Employee is responsible for the balance, thereafter 100% of eligible expenses are paid for that calendar year.

If you live or travel outside of your PPO’s local operating area, Empire and GHI each provide a network of participating doctors, hospitals or labs through the following programs.
BlueCard® PPO Program - Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers. By presenting your Empire I.D. card to a provider participating in the BlueCard® PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. Call 1-800-553-9603 or visit www.empireblue.com to locate participating providers in or outside of Empire’s operating area.

Group Health Incorporated (GHI) QualCare and MultiPlan Network – In addition to GHI’s CPB network in New York State, the QualCare network offers New Jersey residents a comprehensive network of providers, including hospitals, primary care physicians, and specialists. Residents outside New York and New Jersey use MultiPlan. The Multiplan PPO network includes acute care Hospitals and practitioners in 48 states. To locate GHI network ancillary providers (Laboratories, Mental Health, Durable Medical Equipment or Home Health Care vendors) call 212-501-4444 or outside New York City at 1-800-624-2414 or visit www.ghi.com.

As you can see, Empire and GHI will each offer Medical Benefits and Hospital networks on a National level. Therefore, if you elect to enroll with Empire or GHI you will continue to have freedom of choice regarding where to seek medical care.

Here’s an example of how costs compare for in-network and out-of-network care.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Charge</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>Plan Pays Provider</td>
<td>$390</td>
<td>$120</td>
</tr>
<tr>
<td>You Pay Provider</td>
<td>$10 co-payment</td>
<td>$380</td>
</tr>
</tbody>
</table>

The following chart shows you specific plan information.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$0</td>
<td>$200/Individual, $500 /Family</td>
</tr>
<tr>
<td>Copayment (For office visits and certain covered services)</td>
<td>$10 per visit</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Copayment (For hospital inpatient admissions)</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Copayment (For emergency room)</td>
<td>$35 per visit waived if admitted to hospital within 24 hours</td>
<td>$35 per visit waived if admitted to hospital within 24 hours</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>You pay 20% of allowed amount. Plan pays 80% of allowed amount.</td>
</tr>
<tr>
<td>Annual out-of-pocket Coinsurance</td>
<td>$0</td>
<td>$1,000/Individual, $2,500 /Family</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>$1 million per person</td>
</tr>
</tbody>
</table>
SUMMARY OF BENEFITS

The following table provides a summary of your benefits. Where the in-network and out-of-network benefits differ, this is shown on the chart. The benefit amounts listed under the Participating Providers are all based on the PPO discounted allowances. For additional information about any benefit offered by the Plan, review the more detailed description later in this booklet as well as the Exclusions and Limitations on pages 84 – 86. The Plan covers benefits that are Medically Necessary (See Definition on page 59). See pages 32 – 47 for a more detailed description of Medical Benefits.

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS (Doctor Services)</th>
<th>EMPLOYER PAYS</th>
<th>EMPLOYER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFIT</strong></td>
<td><strong>EMPIRE BC/BS</strong> or <strong>GHI</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Physician Visits (Home/Office/Specialist)</td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$10 Co-payment</td>
<td>Not Covered out-of-network</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>$10 Co-payment</td>
<td>Not Covered out-of-network</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>$10 Co-pay/visit</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Allergy Treatment</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Diagnostic Procedures X-Ray and All lab tests</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Diagnostic Procedures MRI’s/MRA’s and other imaging</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>See Description for Precertification Requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Pre-Surgical Testing</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>GHI</td>
<td>EMP</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Surgery (Inpatient and Outpatient)</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Precertification Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL BENEFITS (Preventative Care)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>GHI</th>
<th>EMP</th>
<th>EMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical Exam</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Diagnostic Screening Tests</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Cholesterol, Diabetes, Colorectal cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fecal occult blood test, Segmoidscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prostate Specific Antigen (PSA) in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>asymptomatic males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic PSA</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Well Woman Care</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Office visits, Pap smears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Density testing and treatment</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Mammogram, Ages 35-39 – 1 baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 40 + - 1 per year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child Care</td>
<td></td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>(including immunizations)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn: 1 in-hospital exam at birth</td>
<td></td>
<td>Immunizations covered up to age 19</td>
<td></td>
</tr>
<tr>
<td>Birth to age 1: 6 visits.</td>
<td></td>
<td>Newborn: 1 in-hospital exam at birth.</td>
<td></td>
</tr>
<tr>
<td>Age 1 through 2: 3 visits.</td>
<td></td>
<td>Birth to age 1: 6 visits.</td>
<td></td>
</tr>
<tr>
<td>Ages 3 up to 19th birthday: annual visits.</td>
<td></td>
<td>Age 1 through 2: 3 visits.</td>
<td></td>
</tr>
<tr>
<td>Immunization Benefit</td>
<td></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Immunizations covered up to age 19</td>
<td></td>
<td>Newborn: 1 in-hospital exam at birth.</td>
<td></td>
</tr>
<tr>
<td>Immunizations covered up to age 19</td>
<td></td>
<td>Birth to age 1: 6 visits.</td>
<td></td>
</tr>
<tr>
<td>Immunizations covered up to age 19</td>
<td></td>
<td>Age 1 through 2: 3 visits.</td>
<td></td>
</tr>
<tr>
<td>Immunizations covered up to age 19</td>
<td></td>
<td>Ages 3 up to 19th birthday: annual visits.</td>
<td></td>
</tr>
</tbody>
</table>
## MEDICAL BENEFITS (Emergency Care)

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare</strong></td>
<td><strong>EMPIRE BC/BS&lt;sup&gt;1&lt;/sup&gt; or GHI&lt;sup&gt;1&lt;/sup&gt;</strong></td>
<td><strong>EMPLOYEE PAYS</strong></td>
</tr>
<tr>
<td>Emergency Room Facility Initial visit for Emergency Care</td>
<td>$35 Co-payment Waived if admitted within 24 hours</td>
<td>$35 Co-payment Waived if admitted within 24 hours</td>
</tr>
<tr>
<td>Emergency Room Physician Visit</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulance Local professional ground transportation to the nearest hospital</td>
<td>$0 Ground Transportation only</td>
<td>$0 Ground Transportation only</td>
</tr>
<tr>
<td>World Wide Travel Emergency room facility</td>
<td>$35 Co-payment Waived if admitted within 24 hours</td>
<td>$35 Co-payment Waived if admitted within 24 hours</td>
</tr>
</tbody>
</table>

## MEDICAL BENEFITS (Maternity Care)

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity</strong></td>
<td><strong>EMPIRE BC/BS&lt;sup&gt;1&lt;/sup&gt; or GHI&lt;sup&gt;1&lt;/sup&gt;</strong></td>
<td><strong>EMPLOYEE PAYS</strong></td>
</tr>
<tr>
<td>Maternity - Physician Charges</td>
<td>$10 Co-payment First visit only</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Maternity Facility Charge&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$0 Precertification Required</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Prenatal and Postnatal Care (in doctors office)</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Lab Tests, Sonograms and Other Medically Necessary Diagnostic Procedures</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Routine Newborn Nursery Care (In hospital)</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Obstetrical Care&lt;sup&gt;4&lt;/sup&gt; (In hospital)</td>
<td>$0 Precertification Required</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Obstetrical Care&lt;sup&gt;4&lt;/sup&gt; (In birthing center)</td>
<td>$0 Precertification Required</td>
<td>Deductible and Coinsurance</td>
</tr>
</tbody>
</table>
## HOSPITAL BENEFITS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYEE PAYS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUT-OF-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical Surgical&lt;sup&gt;4&lt;/sup&gt; (except Mental Health)</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Precertification Required</td>
</tr>
<tr>
<td>Unlimited semi-private room &amp; board&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Precertification Required</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Cardiac Rehabilitation&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Precertification Required</td>
</tr>
<tr>
<td>Outpatient Surgery, Chemotherapy, Radiation Therapy,</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Mammography &amp; Cervical Cancer Screening (In Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Kidney Dialysis</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Organ Transplant Benefits&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Precertification required</td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

## DURABLE MEDICAL EQUIPMENT AND SUPPLIES

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYEE PAYS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUT-OF-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Network Supplier Must Precertify</td>
<td>Precertification Required</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
</tbody>
</table>
### Orthotics

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics</td>
<td>$0</td>
<td>Network Supplier</td>
<td>Must Precertify</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

### Prosthetic Appliances

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic Appliances</td>
<td>$0</td>
<td>Precertification Required</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

### Mastectomy Wear

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy Wear</td>
<td>$0</td>
<td></td>
<td>Deductible and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

### Hearing Aid

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aid</td>
<td>Not Covered</td>
<td></td>
<td>See Pg. 41 for covered services</td>
</tr>
</tbody>
</table>

### SKilled Nursing and Hospice Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>$0</td>
<td></td>
<td>Deductible and</td>
</tr>
<tr>
<td>(up to 60 days/calendar year in lieu of hospitalization)</td>
<td></td>
<td></td>
<td>Coinsurance</td>
</tr>
<tr>
<td>Hospice</td>
<td>$0</td>
<td>Limited to 210 days</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification Required</td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

### Home Health Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
<th>Network Supplier</th>
<th>Deductible and Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>$0</td>
<td>Precertification Required</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>(200 visits)</td>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>$0</td>
<td>Network Supplier</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification Required</td>
<td>Out-of-network</td>
</tr>
</tbody>
</table>
## PHYSICAL AND OTHER THERAPIES

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Physical Therapy/ Medicine or Rehab&lt;sup&gt;4&lt;/sup&gt;.</strong></td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Up to 30 days per calendar year</td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td><strong>Outpatient Physical Therapy&lt;sup&gt;4&lt;/sup&gt;.</strong></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Up to 30 visits/calendar year</td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td><strong>Other Short Term Outpatient Rehabilitative Therapies&lt;sup&gt;4&lt;/sup&gt;.</strong></td>
<td>$10 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td><em>(Speech, vision.)</em> Up to 30 combined visits per calendar year</td>
<td></td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

## BEHAVIORAL HEALTHCARE

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEE PAYS</th>
<th>OUT-OF-NETWORK&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health&lt;sup&gt;5&lt;/sup&gt;.</strong></td>
<td>$0</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Up to 30 days per calendar year</td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health&lt;sup&gt;5&lt;/sup&gt;.</strong></td>
<td>$25 Co-payment</td>
<td>Deductible and Coinsurance</td>
</tr>
<tr>
<td>Up to 40 visits per calendar year</td>
<td></td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>
### ALCOHOL OR SUBSTANCE ABUSE

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>EMPLOYEYE PAYS</th>
<th>OUT-OF-NETWORK²,³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Substance Abuse Treatment⁵</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 30 days per calendar year</td>
<td>$0</td>
<td>Deductible and</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td><strong>Inpatient Detoxification⁵</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 7 days per calendar year</td>
<td>$0</td>
<td>Deductible and</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Treatment⁵</strong></td>
<td>$0</td>
<td>Deductible and</td>
</tr>
<tr>
<td></td>
<td>Up to 60 visits, including 20 family counseling visits per calendar year</td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Precertification Required</td>
<td>Up to 60 visits, including 20 family counseling visits per calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification Required</td>
</tr>
</tbody>
</table>

(1) Network provider delivers care.

(2) Out-of-Network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

(3) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider who does not participate within your PPO’s network. (This does not apply to emergency benefits.) See (5) for Mental Health and Alcohol/Substance Abuse Services.

(4) Precertification by your PPO’s Medical Management Program is required or benefits may be reduced by 50% up to $2,500 for each admission, treatment, or procedure. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(5) Precertification by your PPO’s Behavioral Healthcare Management Program is required.

(6) Co-pay waived for Second Surgical Opinion if arranged through Medical Management.
## ADDITIONAL MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs - Pharmacy</strong> (Offered through Caremark formerly AdvancePCS)</td>
<td>$5 Co-payment on Generic. $15 Brand Name Preferred. $30 Non Preferred. 30 day supply.</td>
</tr>
<tr>
<td><strong>Prescription Drugs – Specialty Medication</strong> (See complete list for details)</td>
<td>$5 Co-payment on Generic. $15 Brand Name Preferred. $30 Non Preferred. 30 day supply.</td>
</tr>
<tr>
<td><strong>Prescription Drugs - Mail Order</strong> (Offered through Caremark formerly AdvancePCS)</td>
<td>$5 Co-payment on Generic. $15 Brand Name Preferred. $30 Non Preferred. For each 30-day supply. Up to 90-day supply.</td>
</tr>
</tbody>
</table>
| **Dental Benefits** (Offered through PPO: DDS, Inc.) | **In-Network**: Paid in full up to $3,000/year  
**Out-of-Network**: Paid in accordance with the Fund schedule limited to $3,000/year  
**Note**: There is a $2,500 lifetime orthodontic maximum in or out-of-network |
| **Vision Care Benefit from age 13 and over** (Offered through PPO: Vision Screening) | Up to $100 payable once every 24 months  
No deductible                                                                 |
| **Vision Care Benefit up to age 12** (Offered through PPO: Vision Screening) | Up to $100 payable once every 12 months  
No deductible                                                                 |
| **Life Insurance**                           | Active Eligible Employee: $15,000  
Retired Employee: $5,000  
Local 1 Represented Employee: $3,000 |
| **Accidental Death and Accidental Dismemberment Benefits** | **Accidental Death**: An amount equal to the Life Insurance  
**Accidental Dismemberment**: 50% of Life Insurance amount is paid for loss of one foot, one hand or one eye; 100% of Life Insurance amount is paid for loss of two hands or feet or the loss of both eyes. |
| **Weekly Disability Benefits**               | $215/week based on State Disability Payments. Maximum 26 weeks |
YOUR MEDICAL BENEFITS

Your medical coverage is divided into Medical Benefits, Hospital Benefits and Other Benefits. In some cases, the benefits differ significantly depending on whether you use in-network or out-of-network providers. In other cases, benefits are only available in-network.

When you need to visit your doctor or a specialist, in-Network, you are responsible only for a small copayment. 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 testing, there is only a small copayment. In-Network visits for ongoing treatment 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 are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

- When you make an appointment, confirm that the doctor is a 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 your PPO’s Members Services to confirm that the supplier participates in your network. This will ensure that you receive maximum benefits.

Ask about a second opinion anytime that you are unsure about surgery or cancer diagnosis. Second opinions for surgery are paid in full when arranged by your PPO’s Medical Management Program. The specialist who provides the second opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second opinions are paid at the in-network level, even if you use an out-of-network specialist.

Deductible For Out-of-Network Claims

In each calendar year that an Eligible Employee or Eligible Dependent has eligible out-of-network Medical Benefits and Hospital expenses, the eligible person must pay the Deductible. The Deductible is the amount an Eligible Employee or Eligible Dependent pays before the Plan pays Medical Benefits. The Deductible applies to each eligible person in each calendar year. The annual Deductible is $200 per person but not more than $500 per family.

However, for in-network Benefits, if an Eligible Employee or Eligible Dependent receives services from a Participating Provider, the annual Deductible does not apply and the eligible person pays only a small co-payment amount. There is no Deductible for in-network benefits.
Carry Over Deductible

Any eligible expenses incurred during the last three months of a calendar year, which were applied against that year’s Deductible will be carried over and also applied against the Deductible in the next calendar year.

Covered Services

Medical Benefits cover expenses incurred for surgery, medical care, office and home physician visits, laboratory and x-ray, medical consultation, anesthesia, physical and occupational therapy, medical supplies, annual physical and well woman care exams, well child care, allergy testing and treatment, chiropractic care, orthotics, cardiac rehabilitation, durable medical equipment, prosthetics, home health care, home infusion therapy, blood and ambulance.

Be sure to present your medical identification card any time you or your Dependents receive medical care. If you need to replace your identification card, you can order a replacement card by calling your PPO.

Empire BC/BS Call 1(800) 553 9603 or visit www.empireblue.com
GHI Call 1(800) 223 9870 or visit www.ghi.com

In addition to out-of-network Medical Benefits and Hospital Benefits, the Plan provides a number of other benefits which are not subject to the annual Deductible and which are not applied to the lifetime Medical Benefit limit. These benefits are Vision Care Benefits, Dental Benefits, Prescription Drug Benefits, Life Insurance and Weekly Disability Benefits.

Benefits Required by the Women’s Health and Cancer Rights Act of 1998

As required by the Women’s Health and Cancer Rights Act of 1998, your Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between breasts, prostheses and complications resulting from a mastectomy (including lymph edema). Contact the Fund Office for more information.

Precertification Requirements

Precertification is required when you are admitted to the hospital and for certain tests or procedures. The purpose of the precertification program is to protect your health and the financial integrity of the Fund by preventing unnecessary and potentially harmful treatment.

To receive the maximum available benefits, you or someone on your behalf MUST call the Medical Management Program in the following instances:
### CALL TO PRECERTIFY

<table>
<thead>
<tr>
<th>ALL HOSPITAL ADMISSIONS</th>
<th>HOW COVERED</th>
<th>WHO CALLS TO PRECERTIFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• At least two weeks prior to any planned surgery or hospital admission</td>
<td>In-Network and Out-of-Network</td>
<td>YOU</td>
</tr>
<tr>
<td>• Within 48 hours of an emergency hospital admission, or as soon as reasonably possible</td>
<td>In-Network and Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>• For illness or injury to newborns</td>
<td>In-Network and Out-of-Network</td>
<td></td>
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</tbody>
</table>

### PREGNANCY

- Within the first three months of a pregnancy and again within 48 hours of the actual delivery date
- Maternity facility
- Obstetrical care

### BEFORE YOU RECEIVED

- Inpatient physical therapy
- Same-day surgery for medically necessary cosmetically/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures
- Cardiac rehabilitation
- Diagnostic procedures, magnetic resonance imaging or magnetic resonance angiography scan (MRI or MRA)

### BEFORE YOU RECEIVE

- Hospice care
- Occupational or speech therapy
- Outpatient physical therapy
- Skilled nursing facility care
- Behavioral care or mental health benefits

### BEFORE YOU RECEIVE

- Inpatient/Outpatient Mental health
- Substance abuse treatment
- Inpatient detoxification
- Outpatient substance abuse treatment

### BEFORE YOU RECEIVE

- Home health care services
- Home infusion therapy

### BEFORE YOU

- Receive home infusion therapy
- Rent, purchase or replace prosthetics, orthotics, or durable medical equipment

### If Services are NOT Precertified

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, **benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure**. This benefit reduction also applies to 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. To get the most out of your coverage call your Medical Management Program:

- **EMPIRE BC/BS**: Call 1 800 553 9603
- **GHI**: Call 1 800 223 9870
DESCRIPTION OF BENEFITS

Medical Benefits/Doctor Services

Physician Visits
Eligible Employees and Eligible Dependents are eligible for the following services by a licensed Physician:

- Office Visit
- Hospital Visit
- Specialist Visit
- Emergency Room Visit
- Maternity Care Visit
- Second Surgical Opinion

Chiropractic Care
In-Network Chiropractic Care is paid in full subject to a $10 co-payment, precertification is required. Out-of-Network services are not covered under the Plan.

Acupuncture
The Plan allows for fifteen (15) Acupuncture treatments per year when performed by a M.D. or a Certified Licensed Acupuncturist. In-network Acupuncture Services are paid in full subject to a $10 co-payment. Out-of-network services are not covered under the Plan.

Allergy Testing and Treatment
For in-network allergy testing, there is only a $10 co-payment. In-network visits for ongoing allergy treatment are covered in full. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Diagnostic Procedures
Eligible Employees and Eligible Dependents are eligible for the following X-Ray and Laboratory Benefits:

- In-network x-ray and lab charges are paid in full.
- Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Please note that using an in-network Physician does not insure that the lab is in-network. It is up to the Eligible Employee or Eligible Dependent to verify that the lab is in-network.
Other Diagnostic Procedures *(Precertification Required)*
Eligible Employees and Eligible Dependents are eligible for MRI and MRA Benefits:

- In-network MRI and MRA charges are paid in full.
- Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Second Surgical Opinion
Ask about a second opinion anytime that you are unsure about your surgery or cancer diagnosis. The Plan covers a third surgical opinion if the second surgical opinion differs from the first. However, the Plan does not cover a second or third surgical opinion, if:

- It is with a Physician who is not certified as a specialist in the medical field of the proposed surgery;
- It is with an associate of the Physician who performs the surgery or a Physician who has a financial interest in the outcome of the recommendation;
- It is in connection with proposed surgery for which surgical benefits would not be payable under this Plan;
- Unless the patient is examined in person by the Physician rendering the second opinion; or it is obtained after the surgery is performed;
- For in-network second surgical opinion, there is only a $10 co-payment. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Pre-Surgical Testing
If the patient has surgery, all in-network pre-surgical procedures performed within seven (7) days of the surgery are paid in full. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Surgical Benefits *(Precertification Required)*
Eligible Employees and their Eligible Dependents are eligible for the following Surgical Benefits:

- In-network surgical procedures are paid in full.
- Out-of-network surgical procedures, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Surgical Assistant
If you receive services from an assistant surgeon when you have a covered surgical procedure, the services rendered by the assistant surgeon are payable as follows:

- In-network assistant surgeon charges are paid in full.
- Out-of-network assistant surgeon, you are responsible for the annual
Voluntary Sterilization
The Plan covers voluntary sterilization.

Medical Benefits/Preventative Care

Annual Physical Exam
For Active Eligible Employees and Eligible Dependents of Active Eligible Employees, annual physical in-network charges are paid in full after a $10 co-payment. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Well Woman Care
Benefits for an Annual Gynecological Examination are payable once per calendar year for the Eligible Employee or Eligible Dependent. In-network charges are payable in full after a $10 co-payment. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount. This coverage is for the examination only and does not include the cost of the mammography and other ancillary charges, which are covered under the x-ray/lab and medical portions of the Plan.

Well Child Care
Eligible newborn Dependents are entitled to benefits for well-baby care until the Eligible Dependent reaches two (2) years of age (See table on page 22). After age 2, see Annual Physical. Benefits for services of in-network Physicians are paid in full. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Immunizations
In-network immunizations are paid in full. Out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount. An immunization involves the administration of a preparation that contains all or part of an infectious agent to establish immune resistance to a disease. Immunizations may also be referred to as vaccinations, shots or boosters. Immunizations are medically necessary for the prevention of specific bacterial or viral diseases in both children and adults.

The Fund covers immunizations for those Employees and their Dependents enrolled in one of the PPO Networks. Coverage for adult immunization is available for hepatitis A vaccine, influenza vaccine, Lyme disease vaccine, and pneumococcal vaccine. Immunizations and vaccines are administered according to the guidelines of the United States Center for Disease Control (CDC).

Lyme Disease
The Plan allows for full treatment of three (3) injections to prevent Lyme disease. This vaccine is not part of the annual physical.

**Screening for Volunteers at the WTC Site**
For Employees who volunteered at the World Trade Center site, the Plan covers a $30.00 benefit for a comprehensive medical evaluation program that provides free and confidential medical exams, referral for medical care, and occupational health education for workers and volunteers who provided rescue, recovery, debris removal and sifting and restoration of vital support services at the WTC and Staten Island landfill sites. The $30 payment is a per member payment payable to the World Trade Center Worker and Volunteer Medication Screening Program for any member that volunteered support and who would like additional medical screening.

**Medical Benefits/Emergency Care**
Should you need emergency care, your Plan is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs or parts
- Cause serious disfigurement
- In the case of behavioral health, place yourself or others in serious jeopardy.

**Emergency Room**
Emergency Room Hospital charges for an accident or a sudden and serious illness will be paid in full after a $35 co-payment if Medically Necessary. Charges are waived if you are admitted within 24 hours. If it is determined that the services provided are not considered an emergency, deductible and coinsurance will apply. Fees for services by a non-participating Physician in connection with an Emergency Room visit are paid in full through your PPO.

**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 an in-network hospital.

You are responsible only for a small 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 are responsible for 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 I.D. card when you arrive at the emergency room.**
If you are admitted to the hospital, you or someone on your behalf must call your
PPO network’s Medical Management Program before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from your PPO network’s Medical Management Program within the required time, benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure.

**Ambulance**
The Plan covers professional ground only ambulance services when used to transport a patient from the place where an injury occurred, or where the patient became incapacitated due to a disease, to the nearest Hospital where appropriate treatment can be provided.

**Worldwide Travel**
If you have an emergency outside the United States and visit a hospital, simply show your I.D. card. If the hospital does not participate with your PPO, you will need to file a claim. Your complete benefit program is available when you or your Dependents are traveling. You receive the same benefits as described in this Plan Document. Remember that Medicare does not pay for hospital or other medical expenses outside the U.S. If you plan to travel abroad, consider obtaining additional insurance.

**Medical Benefits/Maternity Care**
Hospital charges for the mother and a newborn baby are paid in full for Eligible Employees, their Spouses and unmarried Dependents. There are no out-of-pocket expenses after the initial office visit co-payment for maternity and newborn care when you use in-network providers. That means you do not need to continue 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 at 100% in-network.

For out-of-network maternity services, you are responsible for the annual deductible, coinsurance and any amount above the allowed amount. Reimbursements for the remaining balance may be consolidated in up to three installments, as follows:

- Two payments for prenatal care
- One payment for delivery and post-natal care
Maternity (Precertification Required)
Whether services are provided in-network or out-of-network, call your PPO’s Medical Management Program within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the plan for the first 30 days if you have family coverage. However, you will need to add the baby’s name as a covered Dependent. If you do not have family coverage, call the Fund Office within 30 days to add your newborn as a Dependent.

Newborns’ and Mothers’ Health Protection Act
In general, expenses related to pregnancy are treated in the same manner as expenses related to illness or injury. In addition, with respect to pregnancy, the word “Hospital” includes alternate birthing facilities under the supervision of a doctor or a licensed nurse-midwife.

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 plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HOSPITAL BENEFITS
Hospital services are covered for most of the cost of your medically necessary care when you stay at a network Hospital for surgery or treatment of illness or injury. When you use an out-of-network Hospital or facility, you are responsible for the annual Deductible and coinsurance, plus any amount above the in-network allowed amount.

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

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

Members and Dependents are eligible to receive the following Hospital Benefits when
medically necessary:

**Inpatient Medical and Surgical** *(Precertification Required)*
Each Eligible Employee and Eligible Dependent are eligible for up to 365 days of Hospital care per calendar year. This coverage includes semi-private room and board and all services required and ordered by your Physician. Conditions that can be treated in a nursing home, long-term care facility or at home are not covered under Hospital care. Personal items such as TV and telephone are not covered.

**Anesthesia Benefits**
Eligible Employees and Eligible Dependents are eligible for the following Anesthesia Benefits:

- In-network anesthesia charges are paid in full.
- Out-of-network anesthesia charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount. However, fees for services by a non-participating anesthesiologist when the services are provided in a participating Hospital are paid in full.

Please note that using an in-network Hospital or in-network Physician does not insure that the anesthesiologist is in-network. It is up to the Eligible Employee or Eligible Dependent to verify that the anesthesiologist is in-network.

**Cardiac Rehabilitation** *(Precertification Required)*
Eligible Employees and Eligible Dependents are eligible for the following Cardiac Rehabilitation Benefits:

- In-network is paid in full subject to a $10 co-payment.
- Out-of-network benefit, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount. The services must be provided following a Hospital discharge. The services must be Medically Necessary. Services are limited to three times per week with a 36 session maximum period of three months.

**Outpatient Ambulatory Surgery, Chemotherapy, Radiation Therapy, Mammography & Cervical Cancer Screening**
If these services are performed in a network Hospital, they are covered under the Hospital benefit which is payable in full. If services are provided out-of-network, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount.

**Outpatient Kidney Dialysis**
The Plan covers outpatient Kidney Dialysis Treatments in full when received from an
in-network provider. For treatments received from an out-of-network provider, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

**Organ Transplant Benefits (Precertification Required)**
Organ Transplant Benefits are covered under the Plan (for non-experimental organ transplants only). If you need an organ transplant, you must contact your PPO’s Medical Management Program.

**Durable Medical Equipment and Supplies**
Your Plan covers the cost of Medically Necessary prosthetics, orthotics and durable medical equipment. The network supplier must precertify the rental or purchase by calling your PPO’s Medical Management Program. When using a supplier outside your PPO’s operating area, you are responsible for precertifying services. A PPO’s network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact your PPO’s Member Services. Out-of-network you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

For prosthetics, orthotics and durable medical equipment, be sure the vendor knows the number to call for Medical Management precertification.

Covered services are listed in *Your Benefits Summary* section. The following are additional covered services and limitations:

**Durable Medical Equipment (Precertification Required)**
Purchase or rental of Durable Medical Equipment such as wheelchairs, walkers, hospital beds, oxygen and rental or purchase of equipment for the administration of oxygen when Medically Necessary as prescribed by an attending Physician, depending on which option is more cost-effective and available, are covered in full when purchased through an in-network provider. In the case of charges for equipment purchased through an out-of-network provider you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a Physician and approved by your PPO’s Medical Management Program, including:
  1. Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
  2. Prescription lenses, if organic lens is lacking
  3. Supportive devices essential to the use of an artificial limb
  4. Corrective braces
  5. 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

Limitations
Covered expenses include Durable Medical Equipment when it is prescribed by a Physician who documents the necessity of the item, it is necessary for the treatment of a disease or injury to improve body function lost as the result of a disease, injury or congenital abnormality or is Medically Necessary to enable the patient to perform essential activities of daily living. Examples of these activities include eating, toileting, bathing, walking, transferring from bed to chair and bed to wheelchair or walker. However, it does not include equipment to enable someone to drive a vehicle, nor equipment solely for the convenience of the patient’s caretaker.

Expenses for Durable Medical Equipment are not covered unless the equipment

1. Is of strong construction for repeated use;
2. Is appropriate for home use and is safe and effective without medical supervision;
3. Is used to serve a medical purpose and is not normally of use to persons who do not have a disease or injury;
4. Is not aesthetic in nature;
5. Is less expensive than alternative equipment;
6. Is not used to enhance the home or environment, to change temperature or humidity or air quality;
7. Is not for exercise or training.

Orthotics (Precertification Required)
The Plan covers orthotics when precertified. In-network orthotics are covered in full. Out-of-network, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Prosthetic Appliances (Precertification Required)
Purchase of Prosthetic Appliances when Medically Necessary as prescribed by an attending Physician are covered in full when purchased through an in-network provider. For Prosthetic Appliances purchased through an out-of-network provider you are responsible for the Deductible and coinsurance, plus any amount above the Plan’s allowed amount.
Mastectomy Wear
When an Employee or Dependant receives a mastectomy the Plan allows for the initial prosthesis and for mastectomy wear. The Plan also allows an additional $750 per calendar year for additional mastectomy wear (this can be used for bras, camisoles or additional prosthesis). For additional benefits please contact the Fund Office.

Hearing Aid
Hearing Aids are not covered in-network. For out-of-network the Plan pays Hearing Aid Benefits in full up to a maximum of $500 payable one time in a thirty-six (36) month period. Claims must be submitted to your PPO.

Skilled Nursing and Hospice Care
In order to receive maximum benefits, please call to precertify skilled nursing and hospice care with your PPO's Medical Management Program.

Skilled Nursing Facility (Precertification Required)
Charges for admission to a skilled nursing facility in lieu of hospitalization are paid in full for Eligible Employees and Eligible Dependents for up to 60 days. You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. Prior hospitalization is not required in order to be eligible for benefits. In an out-of-network facility you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount. Services are covered if the Physician provides:

- A referral and written treatment plan
- A projected length of stay
- An explanation of the services the patient needs,
- The intended benefits of care.

Care is under the direct supervision of a Physician, registered nurse (RN), physical therapist, or other healthcare professional.

Hospice Care Benefits (Precertification Required)
Your Plan covers up to 210 days of hospice care once in a covered person's lifetime. 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 a network hospital, or at home, as long as it is provided by a network hospice agency.

Covered services are listed in Your Benefits Summary section. Following are additional covered services and limitations:

Hospice care services, including:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical care given by the hospice doctor
- Drugs and medications prescribed by the patient’s doctor that are not experimental and are approved for use by the most recent Physicians’ Desk Reference
- Physical, occupational, speech and respiratory therapy when required for control of symptoms
- Laboratory tests, X-rays, chemotherapy and radiation therapy
- Social and counseling services for the patient’s family, including bereavement counseling visits until one year after death
- Transportation between home and hospital or hospice when medically necessary
- Medical supplies and rental of Durable Medical Equipment
- Up to 14 hours of respite care in any week

**Home Health Care**

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage when you use an in-network provider. For out-of-network home health care, you are responsible for 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.

Remember, in order to receive maximum benefits, you need to precertify home health care through your PPO’s Medical Management Program. If you use a home health care agency in-network, the agency is responsible for calling Medical Management. If you use a home health care agency outside your PPO’s network, you need to call Medical Management. (The agency can call for you; however, you need to ensure that they call.)

**Home Health Care (Precertification Required)**

Charges for up to 200 visits (1 visit equals a 4 hour shift) annually of Home Health Care provided by an approved agency are covered when:

- The attending Physician has established a home health care program and certifies that proper treatment would require continued hospitalization in the absence of the home health care program;
• The home health care program has been approved by the Plan prior to the patient’s discharge from the hospital; and

• The number of days for which home health care benefits are payable is subject to re-certification and approval by the Plan prior to the expiration of the original approval.

An in-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. Home health care services include:

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

Home Infusion Therapy Benefits (Precertification Required)
Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network, the supplier must call Medical Management for precertification. While a PPO supplier can call to precertify your treatment, you need to ensure that they call.

If you are outside of the GHI Network’s Home Infusion Therapy participating provider operating area and cannot use a participating provider, please contact GHI’s Coordinated Care Unit at 800 223-9870.

Infusion Therapy Benefits
The Plan covers infusion therapy administered in a Physician's office. Covered benefits include:

• Antibiotic Therapy
• Hydration Therapy
• Pain Management
• Chemotherapy
• Total Parenteral Nutrition (TPN)
• Aerosolized Pentamidine
Physical and Other Therapies

You receive benefits through the plan for physical, occupational, speech and vision therapy. In-network outpatient physical, occupational, speech and vision therapy services benefits are paid in full after a $10 co-payment. For out-of-network benefits you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount. Inpatient physical therapy can be in-network or out-of-network.

Please call your PPO's Medical Management Program to precertify all physical, occupational, and speech therapy. This will ensure that you receive maximum benefits. Ask for exercises you can do at home that will help you get better faster.

Inpatient Hospital Physical Therapy/ Medicine or Rehabilitation (Precertification required)
Regular Hospital benefits are provided for up to 30 days per calendar year for stays or portions of stays primarily for physical therapy, medicine or rehabilitation. In-network charges are paid in full. Out-of-network, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan's allowed amount.

Outpatient Physical Therapy (Precertification required)
In-network Outpatient Physical Therapy benefits are provided for up to 30 days per calendar year, they are paid in full after a $10 co-payment. Out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Other Short Term Outpatient Rehabilitative Therapies, Speech and Vision Therapy (Precertification required)
Charges eligible for coverage when provided by a licensed or registered therapist as prescribed by an attending Physician on an outpatient basis. Physical therapy does not include chiropractic care. There is a maximum of 30 combined visits payable per family member per calendar year. In-network benefits are paid in full after a $10 co-payment. For out-of-network charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

Behavioral Healthcare

The Welfare Fund realizes that your mental health is as important as your physical health. Your behavioral healthcare benefits cover mental healthcare on an inpatient basis in-network and out-of-network and on an outpatient basis in-network and out-of-network.

Please note that the coinsurance that you pay for out-of-network behavioral healthcare services will not count toward reaching your annual out-of-pocket maximum.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance, when you call the Behavioral Healthcare Management Program to precertify in-network services, a counselor will 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 healthcare, or if you call but do not follow their recommended treatment plan, covered benefits may be denied or reduced as follows:

- 50% up to $2,500 per inpatient admission for mental health
- 50% for each outpatient mental health visit to an in-network provider
- 50% for each professional mental health care visit made during an inpatient stay

**Inpatient Mental Health Benefits (Precertification Required)**

Mental health admissions (other than for treatment of substance abuse) in a Hospital are covered up to a maximum of 30 full days in a calendar year. In-network charges are paid in full, there is no co-payment. In the case of out-of-network charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

**Outpatient Mental Health Benefits (Precertification Required)**

The Plan covers up to 40 outpatient mental health visits per calendar year. In-network there is a co-payment as stated in the Summary of Benefits. In-network charges are paid in full, after a $25 co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan’s allowed amount.

In addition to the services listed in Your Benefits Summary section, the following mental health care services are covered:

- Care from psychiatrists, psychologists or certified 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 certified 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

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.

**Alcohol or Substance Abuse**

The Welfare Fund realizes that your behavioral health is as important as your physical health. Your healthcare benefits cover outpatient treatment for alcohol or substance abuse, and inpatient detoxification both in-network and out-of-network. Inpatient alcohol and substance abuse rehabilitation in a facility is covered in-network and out-of-network.

Please note that, with the exception of outpatient alcohol and substance abuse treatment, the coinsurance that you pay for out-of-network behavioral healthcare services will not count toward reaching your annual out-of-pocket maximum.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance. When you call the Behavioral Healthcare Management Program to precertify in-network services, a counselor will 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 healthcare, or if you call but do not follow their recommended treatment plan, covered benefits may be denied or reduced as follows:

- 50% up to $2,500 per inpatient admission for alcohol/substance abuse detoxification
- 50% for each outpatient alcohol and substance abuse facility or provider visit

**Remember.** When you are admitted in an emergency to a hospital or inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program within 48 hours or as soon as reasonably possible.

**EMPIRE BC/BS**  
Call 1 800 553-9603

**GHI (BMP)**  
Call 1 800 692 7311

If you want to know if a provider or facility is covered in-network, call the Behavioral Healthcare Management Program.

**Inpatient Substance Abuse Treatment (Precertification Required)**
Admissions for treatment of substance abuse are covered for a maximum of 30 days per calendar year. In-network charges are paid in full, there is no co-payment. In the case of out-of-network charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

**Inpatient Substance Abuse Detoxification Treatment (Precertification Required)**
Admissions for treatment of substance abuse detoxification are covered for a maximum of 7 days per calendar year. In-network charges are paid in full, there is no co-payment. In the case of out-of-network charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

**Outpatient Substance Abuse Benefits (Precertification Required)**
The Plan will pay for outpatient substance abuse visits up to 60 visits including 20 family counseling visits per calendar year if provided through the outpatient department of a Hospital. In-network charges are paid in full, there is no co-payment. In the case of out-of-network charges, you are responsible for the annual Deductible and coinsurance, plus any amount above the Plan’s allowed amount.

In addition to the services listed in *Your Benefits Summary* section, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient’s treatment begins. Any family member covered by the plan may receive one counseling visit per day.
- Visits for family counseling are deducted from the 60 visits available for outpatient treatment.
- Out-of-network outpatient treatment at a facility that:
1. Has New York State certification from the Office of Alcoholism and Substance Abuse Services.

2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient’s diagnosis.

VISION CARE BENEFITS

The Plan pays up to $100 for an eye examination and/or prescription eyeglasses for each Eligible Employee and Eligible Dependent once every 24 months. If you receive benefits through the Plan’s PPO provider, Vision Screening, you will receive an exam and glasses from selected frames.

The Plan pays up to $100.00 for an eye examination and/or prescription eyeglasses for each Eligible Dependent Child up to age 12 once every 12 months. Under this Benefit, Eligible Dependents include: The Employee’s unmarried Dependent Child(ren) until the end of the calendar year in which the child reaches age 12. For all Eligible Members and Eligible Dependents age 13 and over, benefits will be paid once every 24-months.
DENTAL BENEFITS

The Plan has established an arrangement with a PPO, Dental Delivery System, Inc. (DDS, Inc.), which provides for a panel of dentists. Use of the dentists in this panel will provide 100% coverage for covered dental services up to the limits of the Plan. If you use an out-of-network provider, Dental Benefits will be paid in accordance with the Plan’s dental fee schedule. The out-of-network provider may not accept this amount as payment in full and you may have out-of-pocket expenses. Benefits are limited to $3,000 per calendar year. For claims over $300, a predetermination request with applicable x-rays, MUST be submitted to DDS, Inc., 1640 Hempstead Turnpike, East Meadow, NY 11554 prior to the work being performed. There is a $2,500 lifetime orthodontic maximum in or out of network.

DENTAL FEE SCHEDULE

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<thead>
<tr>
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<th>Code</th>
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### Dental Limitations

The following dental limitations apply whether services are received from an in-network or out-of-network provider:

1. There is a $3,000 annual maximum per person (Effective 01/01/04).
2. There is a $2,500 lifetime orthodontic maximum.
3. Oral exams, bitewings, prophy, scalings and fluoride covered once every 6 months.
4. Full mouth series is covered once every 36 months.
5. Crowns, bridges, dentures and periodontal surgery is covered once every 60 months.
6. Periodontal services covered for Eligible Employees and Eligible Dependents 18 years of age or older.
7. Orthodontic treatment of Class 1, Class 2 and Class 3 malocclusion - one 24 month case/eligible dependent children to age 19 only.
8. Claims must be submitted within 12 months of the beginning date of service.
9. Fluoride treatments are covered up to age 19 only.
10. Perio Scaling per quad covered at 2 quads per 6 month period.
11. Perio Scaling and Prophy are not covered if received on the same day.
12. Doctor’s office must call DDS, Inc. to verify eligibility (516) 794-7700.
13. Charges related to anesthesia are not covered by the Plan.
PRESCRIPTION DRUG BENEFITS

Using the Caremark (formerly AdvancePCS) Retail Pharmacy Network
When you fill your prescriptions simply present your new Caremark ID card to the pharmacist. Your card contains important information to help the pharmacist process your order correctly.

| Up to 30-day supply through Caremark network pharmacies | $ 5.00 co-pay for generic $15.00 co-pay for preferred brand $30.00 co-pay for non-preferred brand |

Using the Caremark Mail Service
You will need to complete a mail order form for you and your family member who will be utilizing the Caremark mail program. This will set up each member’s Profile in the mail order system with valuable information. Then simply mail the completed form, along with an original prescription written for a 90-day supply and payment. Please note that it will take approximately 14 days to receive your mail order prescription. It may be necessary to obtain two prescriptions from your physician, one for a 30-day supply so you can start or continue your medication without interruption; and one for the 90-day mail order supply. After your script has been filled the first time, and you have available refills, you can re-order your mail script online at www.caremark.com, by calling Caremark Member Services or by mailing in your re-order form that you received with your prescription.

| Up to 90-day supply through Caremark mail order | $ 5.00 co-pay for each 30 day generic $15.00 co-pay for each 30 day preferred brand $30.00 co-pay for each 30 day non-preferred brand |

Please note that the new Pharmacy Benefit is a 3-Tier Formulary Prescription Program. Mail Order is available to members who chose to obtain up to a 90-day supply through Caremark mail order. Most injectables are covered under a separate specialty drug program provided by Caremark’s SpecialtyRx Pharmacy. A complete list is available through Caremark upon request. You can receive up to a 30 day supply of specialty medications at a time.

3-Tier Formulary Plan Design
When you fill your prescriptions your co-payment is determined by the Caremark annual formulary list.

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<th>Tier 2</th>
<th>Tier 3</th>
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<td>Non-Preferred Brand Name Formulary Prescriptions</td>
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Prescription Drug Benefit Exclusions
In addition to the general exclusions, limitations and restrictions contained on pages 84 – 86, the following exclusions, limitations and restrictions apply to Prescription Drug Benefits:

1. Prescription drug co-payments are not reimbursable.
2. Prescriptions may not exceed the maximum supply permitted under Food and Drug Administration (FDA) guidelines, but a 90-day supply of maintenance drugs for long term, continuous use may be obtained through the mail order program if so ordered by the prescribing Physician.
3. The number of refills that may be dispensed is subject to FDA guidelines. Refills
must be obtained within a reasonable time after the exhaustion of the previous supply.

4. The Plan will not pay for drugs or medicines that can be purchased without a prescription, even though a prescription is written for them.

5. The Plan will not pay for prescriptions for devices such as, but not limited to, artificial appliances, therapeutic devices, diaphragms or similar items.

6. The Plan will not pay for drugs or medicines dispensed and charged for by a Physician or by any person other than a registered pharmacist employed by a licensed pharmacy.

7. The Plan will not pay for drugs or medicines that cannot legally be dispensed under Federal or State law at a registered pharmacy (e.g., methadone, experimental or investigational drugs) and drugs not within the purview of FDA regulations (e.g., certain foreign drugs).

8. The Plan will limit fertility drugs to a lifetime cap of $20,000.00 per family.

LIFE INSURANCE

The following Life Insurance is provided for Employees only under the Plan:

Active Eligible Employees: $15,000.00
Retired Employees: $ 5,000.00
Local 1 Represented Employees: $ 3,000.00
(Employees represented by Local Union No. 1 who are employed under the terms of an agreement between Local Union No.1 and an Employer, who are not currently eligible as an Active Employee or a Retired Employee but who previously contributed to the Plan.)
ACCIDENTAL DEATH AND ACCIDENTAL DISMEMBERMENT BENEFITS

The following Accidental Death and Accidental Dismemberment Benefits are provided to Employees only, under the Plan:

Accidental Death: An amount equal to the Life Insurance payable in addition to the Life Insurance.

Dismemberment: For the loss of one hand, one foot or the sight of one eye, or a combination of any two or more such losses, an amount equal to 50% of the Life Insurance is payable.

For the loss of two hands or feet or sight in both eyes, or a combination of any two or more losses, an amount equal to 100% of the Life Insurance is payable.

Accidental Dismemberment means the loss of sight in one or both eyes or the loss of one or both hands or feet by severance at or above the wrist or ankle joint.

Beneficiary:

1. The benefit is paid based upon the last beneficiary designation received in the Fund Office before the death of the Employee. Divorce invalidates a prior designation of the Spouse as beneficiary. If more than one beneficiary is designated, they will share equally unless you specify otherwise. If one beneficiary dies before you, the remaining beneficiaries will share equally.

2. If no beneficiary is designated or if all designated beneficiaries die or are invalidated, payment is made in the following order: (1) surviving Spouse; (2) children; (3) parents; (4) brothers & sisters; and (5) personal representative of the employee’s estate.

3. If benefits are designated to a minor, the Plan may pay the benefits due to the minor to the person having present custody or care of the minor and with whom the minor resides. The recipient on behalf of the minor must agree in writing to apply the payments solely for the minor’s support and must comply with any other conditions established by the Trustees. The Plan may also make payment to a minor by depositing the amount in an insured bank account for the minor and giving notice to the minor.

WEEKLY DISABILITY BENEFITS

If an Active Eligible Employee is eligible for and receiving State Disability Benefits the Employee will receive up to $215 for each week he or she receives State Disability Benefits to a maximum of 26 weeks. The Employee must submit proof that he or she is collecting State Disability Benefits.
BENEFITS FOR RETIRED EMPLOYEES

Retired Employee Benefits Up to Age 65 (Medicare Eligibility)

Non-Medicare eligible Retired Employee Benefits are the same as the coverage for an Active Employee described in the Booklet with the following exceptions:

1. There are no Weekly Disability Benefits.
2. Life Insurance Benefits are $5,000.

Upon your death, your Spouse will be offered the choice to continue the same coverage. The cost of the coverage will be based on your Spouse's age and will be revised annually to reflect changing benefit cost. Your Spouse may continue this coverage until your Spouse becomes eligible for Medicare or until your Spouse remarries, if earlier. However, if your Spouse remarries within 18 months of your retirement, your Spouse will be offered the right to purchase COBRA Continuation Coverage for the remainder of the 18 months.

Retired Age 65 and Over Medicare Eligible Employee Benefits

The Plumbers Local Union No. 1 Welfare Fund provides the following benefits to all Medicare eligible retirees of the Fund and their Medicare eligible Spouses. The eligibility rules for Retired Employees stated on page 10 – 12 of this Summary Plan Description apply. Please note that if your Spouse is also Medicare eligible, then the following benefits apply to both you and your Spouse at no cost to you or your Spouse. If your Spouse is not Medicare eligible, then your Spouse will be covered by the Plan benefits applicable to retirees who are not Medicare eligible. Your Eligible Dependent Children will be covered by the Plan benefits applicable to Dependents.

In addition, if you and your Spouse are covered through this program, upon your death your Spouse will be offered the option to continue this coverage for the remainder of his or her life. There will be a monthly premium that will be charged based upon the cost of the program. Upon your death, if your Spouse is not Medicare eligible, your Spouse will be offered COBRA coverage, which is available for 36 months.
**MEDICARE WRAP-AROUND PLAN SCHEDULE**

**NOTE:** ALL PLAN PAYMENTS ARE BASED UPON MEDICARE APPROVED AMOUNTS AND MADE IN ACCORDANCE WITH THE TERMS AND LIMITATIONS OF THE PLAN. PAYMENTS BY MEDICARE ARE MADE AFTER SATISFACTION OF THE $110.00 ANNUAL DEDUCTIBLE WHERE APPLICABLE. *(Note: Medicare Coverage based on Medicare Premium, Deductibles for 2005)*

<table>
<thead>
<tr>
<th>Service or Supply</th>
<th>Medicare Coverage</th>
<th>Plan Pays</th>
<th>Retiree Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Visits (Primary or Specialist)</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>80% approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment</strong></td>
<td>80% approved amount</td>
<td>20% approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>X-Ray and Lab</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Surgical Benefits</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Surgical Assistant</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Routine Physical Exam</strong></td>
<td>Not covered if routine</td>
<td>Not covered if routine</td>
<td>You pay 100% for routine physical exam</td>
</tr>
<tr>
<td><strong>Immunization Benefit</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Emergency Room (initial visit for emergency care)</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Hospital Care</strong></td>
<td>Hospital</td>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Day 1-60: all but $912</td>
<td>Day 1-60: $912 copay</td>
<td>Day 1-60: $0</td>
</tr>
<tr>
<td></td>
<td>Day 61-90 all but $228/day</td>
<td>Day 61-90: $228/day</td>
<td>Day 61-90: $0</td>
</tr>
<tr>
<td></td>
<td>Day 91-150: all but $456/day</td>
<td>Day 91-150: $456/day</td>
<td>Day 91-150: $0</td>
</tr>
<tr>
<td></td>
<td>150 day limit</td>
<td>150 day limit</td>
<td>Over 150 days: You pay 100% beyond 150 days</td>
</tr>
<tr>
<td></td>
<td>Surgical: 80% of approved amount</td>
<td>Surgical: 20% of approved amount</td>
<td>Surgical: $0 (1)* (2)**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery, Therapy (in-hospital)</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td><strong>Organ Transplant</strong></td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Service or Supply</td>
<td>Medicare Coverage</td>
<td>Plan Pays</td>
<td>Retiree Pays</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Prosthetic Appliances</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Day 1-20: 100% approved amount Day 21-100: all but $114/day 100 day limit/benefit period</td>
<td>Day 1-20: $0 (Medicare) Day 21-100 $114/day Over 100 days $0</td>
<td>Day 1-20: $0 Day 21-100: $0 Over 100 days: You pay 100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% limit of 21 consecutive days</td>
<td>Day 1-21: $0 (Medicare) Over 21 days – not covered</td>
<td>Day 1-21: $0 Over 21 days – You pay 100%</td>
</tr>
<tr>
<td>Inpatient Physical Therapy</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Outpatient Physical Therapy</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Other Outpatient Therapies</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Inpatient Mental Health</td>
<td>Hospital Day 1-60: all but $912 Day 61-90 all but $228/day Day 91-190: all but $456/day 190 day lifetime limit</td>
<td>Hospital Day 1-60: $912 copay Day 61-90: $228/day 190 day lifetime limit</td>
<td>Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>50% of approved amount (limit of 40 visits per year.)</td>
<td>50% of approved amount</td>
<td>50% of approved amount Over 40 visits/year you pay 100%.</td>
</tr>
<tr>
<td>Inpatient Substance Abuse</td>
<td>Hospital Day 1-60: all but $912 Day 61-90 all but $228/day Day 91-190: all but $456/day 190 day lifetime limit</td>
<td>Hospital Day 1-60: $912 copay Day 61-90: $228/day 190 day lifetime limit</td>
<td>Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%</td>
</tr>
<tr>
<td>Outpatient Substance Abuse (Physician Charges)</td>
<td>80% of approved amount</td>
<td>20% of approved amount</td>
<td>$0 (1)* (2)**</td>
</tr>
<tr>
<td>Service or Supply</td>
<td>Medicare Coverage</td>
<td>Plan Pays</td>
<td>Retiree Pays</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Lifetime Limit</td>
<td>None except as result of individual benefit max.</td>
<td>Medical Benefits only limited to $1,000,000 per individual</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*(1) In 2005, you must pay an annual $110 deductible for Part B services and supplies before Medicare begins to pay its share.

**(2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don’t accept assignment.

**ADDITIONAL RETIREE BENEFITS**

<table>
<thead>
<tr>
<th>Vision Care Benefit (Offered through PPO: Vision Screening)</th>
<th>Up to $100 payable once every 24 months No deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aids</td>
<td>Limit $500 every 3 years</td>
</tr>
<tr>
<td>Prescription Drug Benefits Retail – When the prescription is filled at a participating Pharmacy (Offered through Advanced PCS)</td>
<td>$5 Co-payment on Generic. $15 Brand Name Preferred, $30 Co-payment for Non-preferred.</td>
</tr>
<tr>
<td>Prescription Drug Benefits Mail Order – When the prescription is filled through the Mail Order Program (Offered through Caremark formerly AdvancePCS)</td>
<td>90 Day supply Up to a 90-Day supply. For each 30-day supply, $5 Co-payment on Generic. $15 Brand Name Preferred, $30 Co-payment for Non-preferred You must submit a claim for refill at least 21 days prior to your needs to allow sufficient time to process your order.</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$5,000 Retired Employee</td>
</tr>
</tbody>
</table>

**PLEASE NOTE:** There are no dental benefits for retirees provided through the Plan.

**IMPORTANT NOTICE!** IN ORDER TO RECEIVE THE MAXIMUM BENEFITS POSSIBLE YOU AND YOUR SPOUSE MUST ENROLL IN BOTH MEDICARE (PART A) AND MEDICARE (PART B) WHEN ELIGIBLE. YOUR BENEFITS WILL BE PROCESSED AS IF YOU HAVE BOTH MEDICARE PART A AND MEDICARE PART B BENEFITS WHETHER YOU HAVE SIGNED UP FOR THEM OR NOT. THIS MEANS THAT YOUR BENEFIT PAYMENTS WILL BE REDUCED BY THE AMOUNT THAT MEDICARE WOULD HAVE PAID.

**Social Security Administration**  Phone: (800) 772-1213 Web site: www.ssa.gov

**Medicare**  Phone: (800) 633-4227 Web site: www.medicare.gov
DEFINITIONS

Some terms have special meanings when used in this Plan booklet. Some of these terms are defined in the text of the Plan, generally in the section in which they are first used. Other terms are defined below. All defined terms apply throughout the Plan unless indicated otherwise.

**Accident or Accidental** - means an unexpected event causing injury, dismemberment or death which is not due to any fault or misconduct on the part of the person injured and which does not arise from and is not related in any way to the person’s employment or place of employment.

**Hospital** - means a legally constituted general acute care non-governmental institution duly accredited by the Joint Commission on Accreditation of Hospitals and operated for the treatment of acute illness or injured person with facilities for surgery and having 24-hour nursing and full medical services.

An institution for the aged, chronically ill, a convalescent, rest or nursing home is not a Hospital. No benefits are payable to an institution that is not a Hospital unless otherwise stated in the plan.

**Lifetime Benefit ($1,000,000)** - means the total amount of benefits payable by the Plan under Medical Benefits to each Eligible Employee and each Eligible Dependent under the Plan during each individual’s lifetime. Currently it is $1,000,000. It also includes, by Coordination, any benefits paid by the Plan in coordination with another plan such as a group health plan, Medicare or other public agency. It does not include any payments for life insurance, prescription drugs, accidental death or dismemberment benefits or hospital benefits.

**Medically Necessary** - means services or supplies when prescribed as necessary by a Physician legally licensed to practice medicine while prescribing within the scope of her or her expertise when furnished under the laws of the United States. The Plan uses the following criteria for determining Medical Necessity:

1. The treatment is consistent with the symptoms and diagnosis of the patient’s condition;
2. The treatment is in accordance with standards of good medical practice;
3. The treatment is not strictly for the convenience of the patient and his or her family;
4. The treatment is not primarily custodial;
5. The treatment is the most appropriate level of the service or supply.
The Plan has the right to have the person for whom benefits are claimed examined by a professionally qualified practitioner designated and paid for by the Plan (e.g., Physician, Dentist, etc.). Such examination may be repeated so often as may be reasonably required during the pendency of a claim.

**Physician** - means a person who is licensed to practice medicine or to perform surgery in the state in which they practice, who is practicing within the scope of their license and who is providing a service covered by the Plan. Physician includes a doctor of medicine, osteopathy, dental surgery or podiatry. Physician charges also include the services of a qualified professional chiropractor, acupuncturist, physiotherapist, psychologist, optometrist, nurse-midwife and nurse anesthetist.

**PPO (Preferred Provider Organization)** - means a network of medical care providers, including hospitals, physicians, laboratories and radiology facilities, with which the Plan has contracted and who have agreed to reduce their fees for medical services and supplies that may be required by Eligible Employees and Eligible Dependents.

**Prescription Drug** - means a drug dispensed pursuant to a Physician’s or Dentist’s written prescription that meets at least one of the following criteria:

1. It is a legend drug for which Federal Law requires a prescription;
2. It is a prescription requiring compounding; or
3. It is insulin that has been prescribed.

**Specialist** - means a Physician whose practice is limited to a particular branch of medicine or surgery and who is board certified in such branch of medicine or surgery by one of the American boards of medical specialties, the government or other recognized standard-setting health agency that defines standards for specialists.
COORDINATION OF BENEFITS

Coordination of Benefits with Other Plans

Quite frequently, because a member and Spouse are working, family members are covered under more than one plan of health benefits. Realizing there have been many instances of duplication of benefits (i.e., two plans paying benefits for the same dollar of medical expense), a Coordination of Benefits provision has been included for all covered benefits except Life Insurance and Accidental Death & Accidental Dismemberment.

“Coordination” means that benefits from this Plan described in this booklet plus benefits received from other health plans can total, but not exceed, 100% of the allowable expenses for each covered person in each calendar year. This is intended to permit full payment of Allowable Expenses but not duplicate payments.

“Allowable expenses” are any Medically Necessary charges for Hospital, Medical, Dental and Vision benefits and services covered in whole or in part by this Plan (except Life Insurance and Accidental Death & Accidental Dismemberment) and any other plan covering the person making the claim.

Expenses not covered by any plan to which a person belongs are not Allowable Expenses, for example, charges for personal comfort items such as television rental in the Hospital.

Other health plans include group plans (either insured or self-insured) such as health plans available from your Spouse’s employer and Medicare.

How Coordination Works with Another Group Health Plan

This Plan always pays Allowable Expenses after a plan that does not have a Coordination of Benefits provision. In addition, the following rules apply:

- A plan covering an individual as an employee pays benefits before a plan covering an individual as a dependent.

- If someone is covered as a dependent under the plan of both parents, the plan of the parent whose birthday falls earlier in the calendar year (regardless of age) will pay benefits before the plan of the other parent. This Birthday Rule applies only if both plans include the same rule. If the other plan has a gender rule, then the plan covering the male head of household pays benefits first. If the order of payment is still not established, the plan of the parent that has covered the dependent for the longer period of time pays benefits first unless this plan covers that parent as a laid off or retired employee and the other parent is covered as an active employee. In this case, the plan of the parent who is an active employee pays benefits first.
• If a member and Spouse are both Eligible Employees under this Plan, benefits will be paid first as if this Plan were the primary plan and then as if this Plan were the secondary plan. This will provide the same coverage as if the Spouses had been covered by two separate plans.

• The following special rules apply for dependent coverage in the case of legal separation or divorce:
  - If the parent with custody has not remarried, the plan covering the parent with custody pays benefits first. The plan covering the parent without custody pays benefits second.
  - If the parent with custody has remarried, the plan covering the parent pays first, the plan of the stepparent with whom the dependent resides pays second and the plan of the parent without custody pays third.

How Coordination Works with Medicare

Medicare Coordination at Age 65 for Active Employees

At age 65 you become eligible for Medicare benefits. As long as you continue to work and have enough hours or make the required self-payments, you continue to be covered by the Plan’s medical benefits as an Active Employee. Medical benefits provided by the Plan will be your primary coverage (and your Spouse’s, if he or she is also eligible for Medicare), and Medicare benefits will be secondary. You will have the benefit of two coverage’s. As long as you remain eligible due to hours worked or employee self-payments, you should continue to submit your claims to the Plan. After payment by the Plan, you can submit any remaining expenses to Medicare for possible payment.

Active disabled employees (as defined in Federal Regulations) also receive primary coverage from the Plan and secondary coverage from Medicare as described above.

In making your decision whether to enroll in Medicare, the following points should be kept in mind:

• Having coverage under this Plan and Medicare obviously provides the greatest protection;

• You are responsible for enrolling in Medicare;

• Be sure to consider how long you expect to work and what will happen to your coverage when you stop working. You may not be able to enroll in Medicare exactly when the coverage of this Plan stops.

The Plan recommends but does not require that Active Employees age 65 or over and Spouses of Active Employees age 65 or over enroll in Medicare Parts A and B when first eligible.
Medicare Coordination for **Retired** Employees

If you are a retiree or an inactive disabled Employee and become eligible for Medicare, Medicare will be your primary coverage. After Medicare has covered the expense, the Plan will pay benefits. You will have to satisfy any applicable Deductible whether or not the medical services are covered or not covered by Medicare.

Medicare has two parts, Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers inpatient Hospital care and generally is available to all individuals age 65 and over at no cost. Part B covers Physician services, outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Part B. To have adequate coverage, you and your Spouse must sign up for both Medicare Part A and Part B when eligible.

All medical claims after your enrollment in Medicare must be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare Explanation of Benefits to the Plan.

The Plan’s medical payment will coordinate with Medicare’s payment. For covered expenses, the Plan will figure its benefit based on the Medicare approved amount and then subtract the Medicare benefit and consider the balance under the provisions of the Plan. For these expenses, the Plan A carves out Medicare payments. However, Federal Law limits the amount a provider (Hospital, Physician, etc.) can charge above the Medicare payment. The Plan cannot pay the provider more than that amount and the provider cannot legally bill you more than that amount.

Enrolling in Medicare

It is important that you or your Eligible Dependent visit an office of the Social Security Administration during the three-month period prior to the 65th birthday, or earlier if you are disabled, to learn all about Medicare. For questions on coverage by this Plan, or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office. Remember, the Plan will pay benefits as if you have both Medicare Part A and Part B benefits whether you sign up for them or not.

A retired Employee and his or her Eligible Dependents will lose active eligibility for benefits upon the Employee’s 65th birthday, or earlier if you are disabled. The Plan’s active eligibility rule (Active Eligible Employee and his Eligible Dependents will lose eligibility for benefits on the last day of the sixth month following the most recent period of three consecutive months in which the Employee works at least 270 hours in Covered Employment) does not apply.

**HOW TO FILE A CLAIM**
General Rules - IMPORTANT
In order to receive benefits from the Plan, a claim must be made as described in these procedures. The Employee or Dependent may make claims directly or through a provider subject to the limitations on assignments. There are special procedures for some claims as explained below. There are also different addresses for filing claims depending on the PPO network in which you participate or if the claim is an Out of Network claim. There are also different addresses for different types of claims. Please review the following procedures carefully.

A claim is considered filed as soon as a written claim form is received at the correct address stated on page 67 – 71 by mail, personal delivery, or fax. Telephone calls and e-mails are not acceptable. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by billings from the provider and such other proof as may be required by the Plan.

Some types of requests to the Plan are not considered claims. For example, requests for a determination whether a person is eligible for benefits or whether a particular benefit that does not require pre-approval will be paid are not claims. Casual inquiries about benefits or the circumstances under which benefits might be paid are also not claims. The Plan may respond to inquiries that are not claims but these rules and the appeal procedures discussed below do not apply.

Some benefits require pre-certification or pre-approval (see pages 30 – 47) but most benefits do not require pre-approval. It is important to obtain pre-approval when it is required and your failure to do so may mean that a benefit is not paid. Failure to comply with this requirement could result in a reduction of benefits up to 50% or maximum of $2,500. To get the most out of your coverage call

- Empire BC/BS  1-800-553-9603
- GHI   1-800-223-9070

Claims must be filed as soon as reasonably possible after the expense is incurred. We recommend that you send a claim for benefits to the Plan within 90 days of the date of service. Any claims submitted after one year from the date of service will not be considered unless you were eligible at the time of service and the medical service provider failed to bill you or the applicable PPO within one year of the date of service. However, the one year claims limitation does not apply when eligibility is established retroactively due to the payment of delinquent contributions. Empire BC/BS allows Employees to submit claims up to 18 months from date of service.

You and your Eligible Dependents, if any, must have a completed enrollment form on file at the Fund Office. Neither you nor your Dependent will be eligible for any benefits unless the completed enrollment form is on file.
In determining eligibility for any benefit, the Plan has the right to have the person for whom
the benefits are claimed examined by a professionally qualified practitioner designated and
paid for by the Plan (e.g., Physician, Dentist, etc.). Such examination may be repeated as
often as may be reasonably required while the claim is pending.

You may designate a representative to act on your behalf in filing a claim or an appeal of a
denial of a claim or other adverse determination. If the Fund Office or claims processor as
applicable is uncertain whether or not you have designated a representative, the Fund
Office may request that you put such designation in writing and may decline to
communicate with a third party claiming to be a representative until such written
designation is received.

Both in determining initial claims and in deciding appeals, the reviewer will make all
determinations in accordance with the applicable Plan document, PPO contract, policies
and rules and will apply the provisions consistently, to the extent reasonable, with respect
to similarly situated claimants.

Throughout the procedures set forth above, there are several time limits within which a
claimant must file a claim or appeal and within which the claims processor or the reviewer
must issue a decision on such claim or appeal. The applicable claims processor or
reviewer may agree to extend the time limits within which the claimant must file and the
claimant may agree to extend any time limit within which the claims processor or reviewer
must issue a decision. The agreement to extend a time limit must be knowing, explicit, and
confirmed in writing before the time period in question expires.

Types of Claims - Definitions

As described below, the procedures that apply to claims differ depending on whether your
claim involves “urgent care,” is a “pre-service claim,” or is a “post-service claim.” These
and other important terms are defined in this subsection.

Urgent Care Claim - This is a pre-service claim that (1) involves emergency medical care
needed immediately in order to avoid serious jeopardy to your life, health, or ability to
regain maximum function; or (2) in the opinion of a Physician with knowledge of your
medical condition would subject you to severe pain if your claim were not dealt within the
“urgent care” time frame described below. Whether your claim is one involving urgent care
will be determined by an individual acting on behalf of the Plan, applying an average
layperson’s knowledge of health and medicine. If a Physician with knowledge of your
medical condition determines that your claim is one involving urgent care, the Plan will treat
your claim as an urgent care claim. Post-service claims are not Urgent Care Claims
because pre-approval is not required before you can receive treatment.

Pre-service Claim - This is any claim for which the terms of the Plan condition receipt of
the benefit, in whole or part, on approval of the benefit in advance of obtaining medical
care. See pages 30 - 47 for information concerning which benefits require pre-approval.
Post-service Claim - This is any claim for a benefit that is not a pre-service claim. In the case of this type of claim, you request reimbursement after medical care has already been provided. Most of the benefits provided by the Plan are post-service claims.

Concurrent Care Claim - This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be either an urgent care claim, a pre-service claim, or a post-service claim.

Incomplete Claims - A claim is incomplete if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Plan your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.

Filing Claims for Hospital and Medical Benefits (For Employees and Dependents enrolled in Empire BC/BS and GHI).

The Plan makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the PPO’s networks, 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, from non-participating providers, or if you have a medical emergency out of the PPO’s service area. To obtain a claim form, call the PPO’s customer service listed on page 90.

<table>
<thead>
<tr>
<th>TYPE OF CLAIM</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL</td>
<td>Provider files claim directly with PPO*</td>
<td>Provider files claim directly with PPO*,</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>Provider files claim directly with PPO*,</td>
<td><strong>You file claim with PPO</strong></td>
</tr>
<tr>
<td>AMBULANCE CHARGES</td>
<td>Provider files claim directly with PPO*,</td>
<td><strong>You file claim with PPO</strong></td>
</tr>
</tbody>
</table>

* Note: For Employees enrolled with Empire BC/BS, provider files claim directly with Empire BC/BS or local Blue Cross/Blue Shield plan.

For Employees enrolled with GHI, provider files claim directly with GHI or local Multi Plan.

In-Network Hospital and Medical Benefit Claims - If you or one of your Eligible Dependents receive medical care and or are admitted to a Hospital as an in-patient, present your Identification Card to the admitting office. Present this card to the Hospital emergency room for treatment due to an accident. The Plan will pay the Hospital directly for covered services. You are responsible for all personal items such as telephone, T.V., etc. The participating provider or Hospital will accept PPO network allowance as full payment, less any applicable copayment. Some services require pre-certification. Refer to the chart on page 31.
Out-of-Network Hospital and Medical Benefit Claims - You should send any Out-of-Network claim for benefits to the PPO in which you are enrolled at the address stated below, within 90 days of the date of service. Any claims submitted after one year from the date of service will not be considered unless you were eligible at the time of service and the medical service provider failed to bill you or the applicable PPO within one year of the date of service. However, the one year claims limitation does not apply when eligibility is established retroactively due to the payment of delinquent contributions. Empire allows Employees to submit claims up to 18 months from date of service.

For Employees enrolled with Empire BC/BS

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

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

For Employees enrolled with GHI

Hospital Claims:
Group Health Incorporated
P.O. Box 2833
New York, NY 10116-2833
Attention: Institutional Claims Department

Medical Claims:
Group Health Incorporated
P.O. Box 3000
New York, NY 10116-3000
Attention: Medical Claims Department

Empire Blue Cross/Blue Shield Out of network claims – You should send any Out-of-Network claim for benefits to the PPO in which you are enrolled at the address stated above, within 90 days of the date of service. Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your co-payment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or EOB citing the reasons your claim was reduced or denied.

The notification will give you

- The specific reason(s) for denial.
- References to the pertinent plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary.
- An explanation of claims review procedures.

If you have any questions about your claim, your PPO may be able to help you answer them. You may also contact Empire Member Services at 1-800-553-9603,
www.empireblue.com or in writing. When you call, be sure to have your Empire Blue Cross/Blue Shield I.D. Card number handy, along with any information about your claim. Send written inquiries to the address listed above.

You can also check the status of your claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting www.empireblue.com .

**Group Health Inc. (GHI)** – You should send any Out-of-Network claim for benefits to the PPO in which you are enrolled at the address stated above, within 90 days of the date of service. When you use a network provider, you show your GHI identification card, pay any applicable co-payment, Deductible, or co-insurance charges, and that’s it. The provider files the claim for you and awaits reimbursement from GHI.

If you have any questions about your claim, your PPO may be able to help you answer them. You may also contact GHI at 1-212-501-4444, www.ghi.com or in writing. When you call, be sure to have your GHI I.D. Card number handy, along with any information about your claim. Send written inquiries to the address listed above.

You can also check the status of your claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting www.ghi.com .

**Out-of-Network Secondary Claims/Coordination of Benefits** - If you have medical coverage under two plans (Coordination of Benefits with other plans – COB). There may be times when your Spouse has medical coverage under another plan (usually through his or her employer). Other times there may be other coverage that is primary for your Spouse and/or dependent children (such as in cases of a divorce). In order to determine which plan has primary coverage please refer to pages 61 - 62. As a reminder, the Plumbers Local Union No.1 Welfare Fund uses the “Birthday Rule” in determining which plan is primary for Dependent Children.

In cases where the Plumbers Local Union No. 1 Welfare Fund is the secondary coverage, the claims submission procedure is as follows:

1. You receive “covered” services from a provider,
2. The claim is submitted to the primary insurance for processing;
3. You receive an Explanation of Benefits (EOB) from the primary insurance;
4. You file a claim for benefits with the Plumbers Local Union No.1 Welfare Fund by sending a completed claim form, Explanation of Benefits (EOB) from the primary insurance and an Itemized Bill from the provider to your PPO at the address stated above;
5. Your PPO will process the secondary claim, the benefits will be reduced so that the total benefits paid by both plans will not be greater than the allowable expenses. Also, the Plan will not pay more than the amount the Plan would normally pay if the Plan were primary.

**Medicare Wrap-Around Claims/Coordination of Benefits** - For Medicare Eligible Claims the Plan provides benefits on a secondary basis (Medicare is primary as
long as the member is not an active Employee). Since your benefits are provided through the Plan on a secondary basis, the Plan will make payment on a claim only after Medicare has processed the claim for payment.

In cases where the Plumbers Local Union No. 1 Welfare Fund is the secondary coverage and Medicare is primary, the claims submission procedure is as follows:

1. You receive “covered” services from a provider,
2. The claim is submitted to Medicare, the primary insurance for processing;
3. You receive an Explanation of Benefits (EOB) from Medicare, the primary insurance;
4. You file a claim for benefits with the Plumbers Local Union No. 1 Welfare Fund by sending a completed claim form, Explanation of Benefits (EOB) from Medicare the primary insurance and an Itemized Bill from the provider to the Plan’s third party claims processor “Administrative Services Only, Inc.” at the address stated below*.
5. The Plan will process the secondary claim for payment to you the member or to provider of services if the member requests an assignment of benefits.

*If a provider submits the claim directly to the Plan’s third party claims payer “Administrative Services Only, Inc.”, without a Plumbers Local Union No. 1 Welfare Fund claim form attached, this is acceptable only if the claim is accompanied by the EOB from the primary insurance. If the claim is submitted directly from the provider without the EOB you will be notified of the incomplete claim.

Plumbers Local Union No.1 Welfare Fund  
c/o Administrative Services Only, Inc.  
303 Merrick Road  
Lynbrook, NY  11563-9010  
Phone: (516) 396-5500

Prescription Drug Benefit Claims/Mail Order Drug Benefit Claims - There are special procedures for making claims for the Prescription Drug Benefit. If you fill the prescription at a participating pharmacy (in network), you do not have to complete a written claim form, you just present the card to the participating pharmacy. At a participating pharmacy (in-network) you are responsible only for a $5 co-payment for generic prescriptions, a $15 co-payment for preferred brand prescriptions and a $30 co-payment for non-preferred brand prescriptions.

You may also get your prescription filled at an out-of-network pharmacy but you must then obtain a claim form and submit the claim to the Prescription Drug Administrator, noted below, for reimbursement. This only applies to prescriptions filled by out-of-network pharmacies. Over the counter medication for which a prescription is not legally required are not covered by the Plan.

Caremark (formerly AdvancePCS)  
P.O. Box 853901  
Richardson, TX 75085-3901  
Phone: (866) 831-4336
If Caremark denies any claim for prescription drugs in whole or in part, you have the right to seek a review by the Trustees of the Fund in accordance with the procedures below.

Under the Mail Order Drug Program, generic prescriptions will be filled at the cost of $5 co-pay for each 30 day supply. For preferred brand name prescriptions, there is a co-payment of $15 for each 30 day supply. For non-preferred brand name prescriptions, there is a co-payment of $30 for every 30 day supply. You must submit a claim form to:

**Caremark** (formerly AdvancePCS)
P.O. Box 3223
Wilkes-Barre, PA 18773-3223
Phone: (866) 831-4336

For refills, a claim must be submitted at least 14 days before you need the prescription to allow sufficient time to process your claim.

If Caremark denies any claim for prescription drugs in whole or in part, you have the right to seek a review by the Trustees of the Plan in accordance with the procedures below.

**Dental Benefit Claims** – There are no claims to submit when you use the services of one of the PPO network providers. If you use the services of an out-of-network provider, the claim should be submitted to the Dental Network Administrator, noted below, for processing.

**Dental Delivery Services, Inc. (DDS)**
1640 Hempstead Turnpike
East Meadow, New York 11554
Phone: (800) 255-5681

You are required to obtain pre-approval of claims over $300. Therefore, these are pre-service claims. However, claims for emergency services only do not require pre-approval even if they exceed $300. Therefore, there are no urgent care dental claims.

If DDS denies any claim for dental services in whole or in part, you have the right to seek a review by the Trustees of the Plan in accordance with the procedures below.

**Vision Care Benefit Claims** - If you use the network provider there is no claim form to submit. However, if you go to an out-of-network provider, you must submit a Claim Form with the completed Member Statement to the Claims Processor, noted below, with the original paid bills (photocopies are not accepted).

**Vision Screening, Inc.**
1919 Middle Country Road, Suite 304
Centereach, New York 11720
Phone: (800) 652-0063

If Vision Screening, Inc. denies any claim for vision services in whole or in part, you have the right to seek a review by the Trustees of the Plan in accordance with the procedures below.
Life Insurance and Accidental Death & Accidental Dismemberment - Upon receipt of notification of the death of an Eligible Employee or Retired Employee, the Plan will provide the necessary forms to be completed by the Beneficiary. Claims forms should be submitted to:

Plumbers Local Union No. 1 Welfare Fund  
158-29 George Meany Blvd.  
Howard Beach, NY 11414  
(718) 835-2700

If the deceased Employee has named no Beneficiary, or the named Beneficiary died before the Employee, payment of any benefit will be made as provided in the Plan.

If your claim for life, accidental death or dismemberment benefits is denied in whole or in part, you have the right to seek a review by the Trustees of the Plan in accordance with the procedures below.

Notice of Initial Benefit Determination

Urgent Care Claims - The Plan or its claims processor will decide your claim and notify you of the decision as soon as possible but not later than 72 hours after your claim is received at the proper address, unless your claim is incomplete. The Plan will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Plan may notify you orally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Plan will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

Pre-service Claims - The Plan or its claims processor will decide your claim and notify you of the decision within a reasonable time, but not later than 15 days after receipt of your claim at the proper address. This period may be extended by one 15-day period, if circumstances beyond the control of the Plan require that additional time is needed to process your claim. If an extension is needed, the Plan will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Plan expects to reach a decision. If the Plan needs an extension because you have submitted an incomplete claim, the Plan will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Plan may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan sends you the notification of the extension until the date you respond to the request for additional information.
**Post-service Claims** - The Plan or its claims processor will decide your claim and notify you of the decision within a reasonable time, but not later than 30 days after receipt of your claim at the proper address. This period may be extended by one 15-day period, if circumstances beyond the control of the Plan require that additional time is needed to process your claim. If an extension is needed, the Plan will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Plan expects to reach a decision. If the Plan needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan sends you the notification of the extension until the date you respond to the request for additional information.

**Concurrent Care Claims** - If the Plan or its claims processor has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Plan or its claims payer will notify you of its determination within 24 hours after receiving your claim, provided that the Plan receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate timeframe, depending on whether it is a pre-service or post-service claim.

**Disability and Dismemberment Claims** - The Plan or its claims processor will decide your disability or dismemberment claim and notify you of the decision within a reasonable time, but not later than 45 days after receipt of your claim at the proper address. This period may be extended by up to two additional 30-day periods, if circumstances beyond the control of the Plan require that additional time is needed to process your claim. If an extension is needed, the Plan will notify you prior to the expiration of the initial 45-day period or the first 30-day extension period of the circumstances requiring an extension and the date by which the Plan expects to reach a decision. If the Plan needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan sends you the notification of the extension until the date you respond to the request for additional information.
Notice of Denial of Claim

If a claim for Hospital, medical, prescription drug, dental, vision, life, accidental death or dismemberment benefits is denied, in whole or in part, the Plan or the applicable PPO or third party claims processor will provide you with a written notice that states the specific reasons for the denial, refers to the specific Plan provisions on which the denial is based, describes any additional material or information that might help the claim, explains why that information is necessary, and describes the Plan’s review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA.

If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, you will be provided either with the specific rule, guideline, protocol or similar criterion, or will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you upon request.

If the adverse determination is based on a Medical Necessity determination or experimental treatment or similar exclusion or limitation, you will be provided either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning an urgent care claim, the notice will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

Right to Review Denied Claims/Appeal Procedure

If a claim for benefits is denied, in whole or in part, you may request a review of the benefit denial. Different procedures apply depending on the PPO network in which you are enrolled. All appeals must be in writing and must be received at the appropriate address within 180 days after you receive the claim denial notice from the claims processor. Failure to file a timely written appeal will result in a complete waiver of your right to appeal, and the decision of the claims processor will be final and binding.

In presenting an appeal, you have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. You are also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Personal appearances on appeals are not permitted.

The review will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted to or considered by the claims processor in its determination. The review will also not afford deference to the initial determination by the claims processor.

In deciding an appeal of a determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other
item is experimental, investigational, or not Medically Necessary or appropriate), the reviewer will consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the claims processor in connection with its initial determination. The identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process without regard to whether that advice was relied on will be provided upon request.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the claims processor did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Plan policy, determination or action. The reviewer can best consider your position if they clearly understand your claims, reasons and/or objections.

Requests for review of denied Hospital and medical benefit claims should be sent to the following addresses:

The review on appeal for all claims will be made by Empire Blue Cross/Blue Shield (See pages 75 – 79).

Empire Blue Cross/Blue Shield - Hospital and medical claims:
P.O. Box 1407
New York, NY 10008

The review on appeal for pre-service claims will be made by GHI. The review on appeal of post-Service claims will be made by the Trustees of the Plan (See pages 79 – 80).

Group Health, Incorporated (GHI) - Medical claims and Hospital claims
P.O. Box 2809
New York, NY 10116 - 2809

Medicare Wrap-Around Claims, Prescription Drug Claims, Dental Claims, Vision Claims, Life, Accidental Death and Dismemberment Claims, the review on appeal will be made by the Trustees of the Plan or a designated Committee of the Plan (See page 80).

Submit request for review to:

Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700
In the case of each reviewer, the decision will be made by individuals none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The reviewer deciding the appeal will give no deference to the initial denial or adverse determination.

Also, in case of an urgent care claim, you may request review orally or in writing, and communications between you and the reviewer (Empire Blue Cross/Blue Shield or GHI as applicable) may be made by telephone, facsimile, or other similar means.

**Timing of Review Decision and Notification**

**Empire Blue Cross Blue Shield Appeal Process**

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

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

**Concurrent Requests.** Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. We will complete all concurrent reviews of services within 24 hours of our receipt of the request.

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

If Empire’s Medical Management Program does not meet the above time frames, 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 section in this booklet titled “Complaints, Appeals and Grievances” 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 their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Empire Blue Cross/Blue Shield – An appeal is a request to review and change an adverse determination (i.e., denied authorization for a service) made by Empire’s Medical Management Program or Behavioral Health Management Program that a service is not medically necessary or is excluded from coverage because it is considered experimental or investigational.

Appeals may be filed by telephone or in writing.

Level 1 Appeals - A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date. Qualified clinical professionals who did not participate in the original decision will review your appeal.

Empire will make a decision within the following timeframes for 1st Level Appeals.

- **Precertification.** We will complete our review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.

- **Concurrent.** We will complete our review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.

- **Retrospective.** We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of our determination to you or your representative, and your provider, within two business days of reaching a decision. If Empire’s Medical Management Program does not make a decision within 60 calendar days of receiving all necessary information to review your appeal, Empire will approve the service. If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.

Remember - A Level 1 Appeal submitted beyond the 180-calendar-day limit will not be accepted for review. A Level 2 Appeal submitted beyond the 60-business-day limit will not be accepted for review.
**Expedited Level 1 Appeals** - You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue healthcare services, procedures or treatments that have already started
- You need additional care during an ongoing course of treatment
- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

- You or your provider will have reasonable access to our clinical reviewer within one business day of Empire’s receipt of the request.
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options. If Empire’s Medical Management Program does not make a decision within the appropriate time frames listed above, Empire will approve the service.

**Level 2 Appeals and Timeframes** - If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If the appeal is not submitted within that timeframe, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone and in writing.

Empire will make a decision within the following timeframes for 2nd Level appeals:

- **Precertification.** We will complete our review of a precertification appeal within 15 calendar days of receipt of the appeal.
- **Concurrent.** We will complete our review of a concurrent appeal within 15 calendar days of receipt of the appeal.
• **Retrospective.** We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

**Level 1 Grievances** - A grievance is a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity. For example, a claim was denied because the member did not obtain precertification for services.

A Level 1 Grievance is your first request for review of Empire’s administrative decision. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar-day limit will not be accepted for review. If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

Empire will make a decision within the following timeframes for 1st Level Grievances:

- **Pre-service** (*services have not yet been rendered*). We will complete our review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.

- **Post-service** (*services have already been rendered*). We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

**Level 2 Grievances** - If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire within 60 business days from receipt of the notice of the letter denying your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, we will not review it and the decision on the Level 1 Grievance will stand. We will acknowledge receipt of the 2nd Level Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance. Empire will make a decision within the following timeframes for 2nd Level Grievances:

- **Pre-service.** We will complete our review of a pre-service grievance within 15 calendar days of receipt of the grievance.

- **Post-service.** We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

**Expedited Grievances** - You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within 72 hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

**Decision on Grievances** - Empire’s notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire’s decision
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision

**How to File an Appeal or Grievance** - To submit an appeal or grievance, call Member Services at 1-800-342-9816, or write to the following address with the reason why you believe the administrative decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire Blue Cross/Blue Shield
Appeals and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

**Group Health Inc. (GHI) Appeal Process** – You have the right to appeal any Adverse Determination made by GHI relative to a Hospital admission, extension of stay or other health care service that has been reviewed and determined by GHI to be medically unnecessary and, therefore, not covered. You have the right to designate a representative to appeal any such Adverse Determination on your behalf.

A Utilization Management Appeal must be filed via telephone or in writing within 45 days from the time you receive all the information necessary to file the appeal and GHI’s notification of an Adverse Determination. When filing a Utilization Management Appeal, please include your GHI identification number as well as any applicable claim number(s). Your request should also include any other data and comments, which you believe, support your appeal.

Oral Utilization Management Appeals can be initiated by calling toll free 1 (888) 906-7668.

Please submit written Utilization Management Appeals to:
Standard Appeals - GHI will provide you with written acknowledgment of your Utilization Management appeal within 15 days of GHI's receipt of your appeal. GHI will make a determination on an appeal within 30 days of GHI's receipt of the appeal and any necessary documents needed for GHI to conduct a full and fair review. GHI will notify you of its determination, including the reason for the determination and, if appropriate, the clinical rationale behind the determination, within two (2) business days of GHI's rendering of the determination.

Expedited Appeals (urgent claims) - GHI has an expedited Utilization Management Appeal process for cases involving continued or extended health care services, procedures or treatments, requests for additional services for a member undergoing a course of continued treatment, or cases where the health care provider believes an immediate appeal is warranted due to imminent or serious threat to the health of the member. For expedited appeals, GHI will render a determination within two (2) business days of GHI's receipt of the request for expedited appeal and any documents needed to conduct a full and fair review.

To initiate an expedited Utilization Management Appeal, please call 1 (888) 906-7668. Expedited appeals, which do not produce a result satisfactory to you or your provider, may be further appealed through the Standard Utilization Management Appeal process.

Content of Notification of Decision on Review

You will receive a written or electronic notice of the determination on review. If the appeal is denied in whole or in part, the written notice will include, the specific Plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.
Reviewer's Decision on Appeal is Final and Binding

The decision of each reviewer is final and binding on all parties, including anyone claiming a benefit on the claimant. Each reviewer has full discretion and authority to determine all matters relating to the benefits provided under the portion of the Plan for which the reviewer has responsibility including, but not limited to, questions of coverage, eligibility, and methods of providing or arranging for benefits. Each reviewer also has full discretion and authority over the standard of proof required for any claim and over the application and interpretation of the portion of the Plan for which the reviewer has responsibility. In the case of reviews conducted by the Trustees of the Plan, the Fund Office will maintain records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

If a reviewer denies an appeal, and the claimant decides to seek judicial review, the reviewers' decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No lawsuit may be brought without first exhausting the above claims and appeals procedure. Nor may any evidence be used in court unless it was first submitted to the appropriate reviewer prior to the decision on appeal.
SUBROGATION

Cases Involving a Third Party
This Plan will pay covered benefits if you should become injured directly or indirectly by another party. If you should recover damages from an insurance company or from the other party (for example, in a lawsuit), then you must reimburse the Plan for the payments it has made in connection with your injury. If you are injured by another party, you are required as a condition of receiving benefits from the Plan to sign a form acknowledging the Plan’s right to recover under the terms of the Plan. The Plan’s subrogation right is established by the Plan and not by the form. In the event you receive benefits in such a case the Plan’s subrogation interest in your recovery is governed by the terms of the Plan whether or not you signed the form.

Under the terms of the Plan, the acceptance of benefits by an Employee or beneficiary who has been injured by another party or someone acting on his or her behalf constitutes an agreement by the injured party to reimburse the Plan for benefits paid up to the full amount of the recovery due to the injury. The Plan has a right to first reimbursement out of any recovery. By accepting benefits from the Plan, the injured party agrees that any amount recovered by the injured person by judgment, settlement or compromise, and regardless of how the proceeds are characterized, will be applied first to reimburse the Plan even if the Employee is not made whole and without any reduction for attorney’s fees or costs. Amounts recovered by the injured person in excess of benefits paid by the Plan are the separate property of the injured person. In addition, amounts received from a source other than the Plan are the separate property of the injured person if the amounts are received from a policy of insurance for which the injured person or a member of the injured persons family has paid premiums.

By accepting benefits from the Plan, the injured party agrees to notify the Plan promptly if any effort is made to recover from a third party including filing a suit to recover amounts in connection with the injury. Furthermore, in the event the injured party or someone acting on his or her behalf receives payment from any source for claims related to the injury, the injured party agrees to notify the Plan promptly. By accepting benefits from the Plan the injured party agrees that neither the injured party nor anyone acting on behalf of the injured party will settle any claim relating to the accident without the written consent of the Plan.

In the event an injured party accepts benefits from the Plan and amounts are recovered from claims arising from the accident, the amounts recovered are assets of the Plan by virtue of the Plan’s subrogation interest. Such Plan assets may not be distributed without a release from the Plan of its subrogation interest.

In the event monies are recovered and the Plan is not reimbursed to the extent of its subrogation interest in accordance with Plan provisions, the Plan may bring suit against the injured party, insurers and any recipients of the Plan assets improperly distributed without the consent of the Plan. The Plan may recover benefits paid on behalf of the injured party by treating such benefits as an advance and deducting from amounts due to third parties who have provided medical services despite any certification of coverage, which the Plan may have provided to such providers.
Cases Involving Work Related Claims

In general, the Plan does not cover expenses for an illness or injury that arises out of the course of employment. However, an exception exists if you have a work related injury or illness for which a claim has been filed with a worker’s compensation insurance carrier or with a federal or state court or agency. In the event that the claim has been initially denied, then the Plan, upon request, may pay benefits arising from the work related injury or illness.

By accepting these benefits from the Plan, you agree to actively pursue your work related claim and also agree that the Plan has the power to institute, compromise or settle such a claim in your name to the extent of benefits paid. By accepting these benefits, you also agree that any amounts recovered by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, are assets of the Plan and will be applied first to reimburse the Plan, in full and without any reduction for attorney’s fees or costs, for benefits paid due to the work related claim. The Plan must be reimbursed first, even if you are not made whole. Once benefits are paid under this provision, you may not settle your work related claim without the written consent of the Plan.

As a condition of receiving benefits from the Plan, you are required to sign a form acknowledging the Plan’s right to reimbursement under the Plan. The Plan’s right to reimbursement is established by the Plan and not by the form. The Plan’s interest in your recovery is governed by the terms of the Plan whether or not you have signed the form. Therefore, the Plan has the rights described in the section even if you have not notified the Plan.

If monies are recovered and the Plan is not reimbursed to the extent of its subrogation interest in accordance with Plan provisions, the Plan may bring suit against you, any insurers and any recipients of the Plan assets improperly distributed without the consent of the Plan. The Plan may recover benefits paid on your behalf by treating such benefits as an advance and deducting such amounts from benefits, which become due to you and your family until the Plan’s interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage, which the Plan may have provided to such providers.
EXCLUSIONS AND LIMITATIONS

Services and supplies covered by this Plan are subject to the following exclusions and limitations. Please read this section carefully.

Benefits will be reduced or not payable under the following circumstances:

- You are covered by another plan and pursuant to the Coordination of Benefits rules your benefits payable from this Plan are reduced.
- You incur expenses, which are not covered by this Plan.
- You and/or your Dependent fail to refund a benefit paid by the Plan to which you and/or your Dependent were not entitled. In this case, the amount you owe the Plan will be deducted from any benefits to you or any of your Dependents until the amount you owe the Plan is paid in full. The Plan may also file suit against you to collect the amount due the Plan.
- You and/or your Dependent fail to furnish the Plan with any information or document required by the Plan to determine or process a claim.
- The Plan is amended, modified or terminated by the Trustees.

Exclusions and Limitations

The Plan does not pay benefits unless the charge is for services or supplies covered by the Plan. In addition, the Plan does not pay for or limits the following charges, and the amount of any such charges, or charges in excess of the Plan's limit, will be deducted from the individual's expenses before benefits of this Plan are determined:

- Injuries arising out of (or in the course of) any employment for wage or profit, or diseases that are covered by any worker's compensation law, occupational disease law or similar legislation. However, under specific circumstances, the Plan may advance benefits where the work relatedness of the illness or injury is questioned subject to full reimbursement if the illness or injury is later determined to be work related. See page 83.
- Services or supplies not Medically Necessary for the care of the patient's illness or injury or not certified as Medically Necessary by the attending Physician.
- Surgery and related services intended solely to improve appearance. However, surgery and related services which are Medically Necessary to restore bodily function or to correct deformity resulting from disease, accidental injury, congenital anomaly or previous therapeutic process are covered subject to all Plan terms and limits.
- Illnesses or injuries due to war or any act of war, declared or undeclared (including resistance to armed insurrection).
- Charges for services or supplies furnished by or on the behalf of a federal, state or local government or agency or program, unless payment of the charge is legally required.
- Check ups not reasonably necessary for the treatment of an illness or injury (except for Annual Physical Benefits, Well Child Care and Well Woman Care).
- Treatment of the teeth or gums, except:
1. for the repair of non-occupational injuries to natural teeth, or
2. specifically provided dental benefits.

- Medication, services or supplies not prescribed by a Physician or Dentist.
- Services for which no charge is made or for which no charge would be made if no coverage existed.
- Charges that neither the Eligible Employee nor the Eligible Dependent is personally liable to pay.
- Amounts in excess of actual charges, except when required by contract.
- Charges in excess of the Plan’s limitations.
- Charges for services or supplies, which are furnished, paid for or otherwise provided by reason of the past or present service of any person in the armed forces.
- Benefits, services, equipment and supplies that are required as a condition of employment.
- Benefits, services, equipment and supplies promised by an Employer as a result of an agreement (other than an agreement to contribute to the Fund).
- Charges for services provided by an immediate family member related by blood or marriage or an individual who customarily resides in the Eligible Employee’s or Eligible Dependent’s home.
- Hospitalization primarily for diagnostic studies and evaluations, x-ray examinations, laboratory examinations or electrocardiograms except where appropriate by virtue of medical necessity.
- Services or supplies provided before the Eligible Employee or his or her Eligible Dependent became eligible for coverage. Services or supplies provided after the eligibility of the Employee or his or her Dependent has terminated. To be covered, all treatments must be completed while the Employee or Dependent is eligible even if the treatment has been pre-approved.
- Treatment that is experimental, investigational or part of a research program. Experimental or investigational include:
  - any treatment not proven in an objective manner to have benefit for the patient,
  - any treatment that is restricted to use at a medical facility engaged primarily in carrying out scientific studies,
  - any treatment, drug or supply which is not recognized as acceptable medical practice in the United States,
  - Any items requiring governmental approval which was not granted at the time the services were rendered,
  - any service or supply that is available only on approval of an Institutional Review Board (as required by Federal statute), including ones that require completion of an informed consent for experimentation on human subjects (as required by Federal regulations),
  - any treatment that involves drugs not approved by the Food and Drug Administration (FDA), including dosages, combinations and uses that are not approved,
  - any new drug or devise for which an investigational application has been filed with the FDA,
  - any treatment that is available only through participation in FDA Phase I or Phase II clinical trials or Phasé III experimental or research clinical trials sponsored by the National Cancer Institute, and/or
· Any services or supplies that have protocols or consent documents describing them as an alternative to more conventional therapies.

· Services or supplies provided by an institution that is principally a rest or nursing facility, a facility for the aged, chronically ill, or convalescents, or a facility providing custodial, educational or rest cures, or mere maintenance

· Any treatment leading to or in connection with transsexual surgery.

· Any claim submitted more than a year after the date of treatment or service, except as otherwise approved by the Plan.

· Charges in excess of the Lifetime Benefit.

· Charges for or related to in-vitro fertilization or artificial insemination however, prescription drugs in connection with such treatment are covered.

· Charges for broken or missed appointments.

· Treatment to reverse voluntary surgically induced infertility.

· Charges for treatment for which the Eligible Employee or Eligible Dependent has failed to comply with the Plan’s request to be examined by a practitioner designated and paid for by the Plan. See page 65.

· Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition.

· Confinement to an institution that is not a Hospital.

· Charges resulting from the participation in one of the following crimes for which the individual is convicted or pleads guilty or no contest: murder, rape, robbery, burglary, kidnapping, arson, possession and use of illegal explosives, drug trafficking.

· The Plan will not pay for co-payments of any kind.

· Charges for Shock Treatment.

· Charges for Immunization required for travel outside the United States.

· Charges for Hypnosis.

· Charges for LASIK Eye Surgery/Radial Keratotomy.

· Treatment for temporomandibular joint ("TMJ"), including all related expenses. Treatment for TMJ shall be covered only as a dental expense.

· Charges for Biofeedback.

· Charges for or related to weight loss treatment. (Prescription drugs in connection with weight loss, however, are covered.)
HIPAA PRIVACY

Confidentiality and Protection of Your Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will prevent or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected Health Information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. To the extent Protected Health Information is used or disclosed, the Plan will use or disclose only the minimum necessary Protected Health Information to accomplish the intended purpose of the use or disclosure. The Plan has adopted certain written rules and policies to ensure that with regards to its use, disclosure and maintenance of Protected Health Information, it complies with applicable law.

You may be required to submit to the Fund Office a written request for your own Protected Health Information. You may authorize the disclosure of your Protected Health Information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Plan by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

You have the right, with limited exception, to inspect your Protected Health Information on file with the Fund Office and to file with the Office any corrections or amendments you deem appropriate. You also have the right to file a complaint with the Fund Office if you believe your Protected Health Information has been improperly used or disclosed. The Plan has provided Employees with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan’s use and disclosure of Protected Health Information or your rights with regards to this information, you may request a copy of the Notice from the Fund Office.

In most cases, your claims are filed with a PPO or other payer of claims. These organizations are also required to follow the Privacy Rules and must adopt their own Privacy Policies. You will receive additional notice of Privacy Practices directly from these organizations and should contact them directly with any questions or concerns you may have with respect to Protected Health Information they may have.
GENERAL INFORMATION & ERISA RIGHTS

The following information is provided as specified in Section 102(b) of the Employee Retirement Income Security Act of 1974 (ERISA).

Official Name of Plan:
Plumbers Local Union No.1 Welfare Fund

Type of Administration:
Collectively bargained, joint-trusteed labor management trust; self-administered.

Type of Plan:
Hospitalization, Medical, Disability, Dental, Vision, Prescription, Life and Accidental Death & Accidental Dismemberment.

Name and Address of the Administrator, the Plan Office and the Agent for the Service of Legal Process:

The Board of Trustees
Plumbers Local Union No.1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700

In addition, service of legal process may be made on any Plan Trustee.
Names, Titles and Addresses of the Plan Trustees:

**Union Trustees**

**George W. Reilly, Co-Chairman**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**Kevin Brady**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**Dudley Kinsley**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**John J. Murphy**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**Alternate Union Trustees**

**John Feeney**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**Daniel Lucarelli**
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

**Employer Trustees**

**Vito Giachetti, Co-Chairman**
Taggart Associates Corp.
5-33 50th Avenue
Long Island City, NY 11101

**Eugene S. Boccieri**
Duo Plumbing & Heating Corp.
88 Kreischer Street
Staten Island, NY 10309

**Richard V. Turchiano**
Richards Plumbing & Heating Co., Inc.
103 Dobbins Street
Brooklyn, NY 11222

**Vincent Aspromonte**
Aspro Mech. Contractor, Inc.
127-08 Merrick Boulevard
Springfield Gardens, NY 11434

**Alternate Employer Trustees**

**Michael Blau**
Blau Mechanical Corp.
202-28 45th Avenue
Bayside, NY 11361

**Thomas Maniuszko**
Day Night Plumbing and Heating Corp.
87-71 Lefferts Boulevard
Richmond Hill, NY 11418

**Paul A. Campione, Jr.**
P.A.C. Plumbing, Heating & Air
545 Pt. Richmond Avenue
Staten Island, NY 10302

**Salvatore Gamba**
Olympic Plumbing & Heating Corp.
233-08 Linden Blvd.
Cambria Heights, NY 11411
Source of Financing of the Plan and Identity of Any Organization Through Which Benefits are Provided:

Payments are made to the trust by individual Employers under the provisions of Collective Bargaining Agreements between Plumbers Local Union No. 1 and Employers, by individuals through self-payments, and from any income earned from investments of contributions. All monies are used exclusively for providing benefits to Eligible Employees or their Eligible Dependents, and for expenses incurred with respect to the operation of the Plan. The Trustees annually review the funding status of the Plan with the assistance of their professional advisors.

The Plan will provide you, upon written request, information as to whether an Employer is contributing to this Plan on behalf of Employees working under a Collective Bargaining Agreement.

The Plan has arrangements with various Preferred Provider Organizations and claims payers to provide the benefits of the Plan. The following is a list of those providers:

**Mail Order Maintenance Drugs**  
Caremark (formerly AdvanceRS.com)  
P.O. Box 3223  
Wilkes-Barre, PA 18773-3223  
Phone: (866) 831-4336  
Web Site: [www.caremark.com](http://www.caremark.com)

**Prescription Drug Card**  
Caremark (formerly AdvancePCS)  
P.O. Box 853901  
Richardson, TX 75085-3901  
Phone: (866) 831-4336  
Web Site: [www.caremark.com](http://www.caremark.com)

**Physician & Hospital Network**  
Group Health, Incorporated (G.H.I.)  
441 Ninth Avenue  
New York, New York 10001  
Phone: (212) 501-4444  
Web site: [www.ghi.com](http://www.ghi.com)

**Physician & Hospital Network**  
Empire Blue Cross & Blue Shield  
PO Box 1407  
New York, New York 10008  
Phone: (800) 553-9603  
Web site: [www.empireblue.com](http://www.empireblue.com)

**Vision Benefits**  
Vision Screening  
1919 Middle Country Road, Suite 304  
Centereach, New York 11720  
Phone: (800) 652-0063  
Web site: [www.visionscreening.com](http://www.visionscreening.com)

**Dental Benefits**  
Dental Delivery Services (DDS)  
1640 Hempstead Turnpike  
East Meadow, New York 11554  
Phone: (516) 794-7700  
Web site: [www.ddsinc.net](http://www.ddsinc.net)

**Medicare Wrap-Around Claims Processor**  
Administrative Services Only, Inc.
Date of the End of the Plan Year:
December 31

Internal Revenue Service Plan Identification Number:
11-1538293

The Plan Number is:
501

Plan Termination, Amendment or Elimination of Benefits:
The Welfare Fund may be terminated by a document in writing adopted by a majority of the
Union Trustees and a majority of the Employer Trustees. The Fund may be terminated if, in
the opinion of the Trustees, the Trust Fund is not adequate to carry out the intent and
purpose of the Fund as stated in its Trust Agreement, or is not adequate to meet the
payments due or which may become due under the Plan of Benefits. The Fund may also be
terminated if there are no individuals living who can qualify as Employees of Beneficiaries
under the Plan. Finally, the Fund may be terminated if there are no longer any Collective
Bargaining Agreements requiring contributions to the Fund. The Trustees have complete
discretion to determine when and if the Fund should be terminated.
If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to
the date of termination as well as the expenses in connection with the termination; (b)
arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports
which may be required by law; and (d) apply the assets of the Fund in accordance with the
Plan of Benefits including amendments adopted as part of the termination until the assets
of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the
exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of
the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit
of any contributing Employer, the Association or the Union either directly or indirectly.
Upon termination of the Fund, the Trustees will promptly notify the Union, the Association,
Employers and all other interested parties. The Trustees will continue as Trustees for the
purpose of winding up the affairs of the Fund.

In addition, the Trustees have complete discretion to amend or modify the Plan and any of
its provisions, in whole or in part, at any time. This means that the Trustees can reduce,
eliminate or modify benefits as well as improve benefits. The Trustees may also modify
length of coverage for all employees’ dependents and retirees, and eligibility requirements
for coverage.
ERISA Rights Statement

As an Employee in Plumbers Local Union No. 1 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 Employees shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charges at the plan administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the plan including insurance contacts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

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

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each Employee with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a subsequent group health plan, if you have creditable coverage from this plan. You should be provided a certificate or creditable coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation 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 preexisting condition exclusion under a subsequent plan 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 participation, 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 the duty to do so prudently and in the interest of you and other plan Employees 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 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 materials from the plan and do not receive them within 30 days, you may file a suit in 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, which is denied or ignored, in whole or in part, you may file a suit in the 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 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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.