LOCAL UNION NO. 363 I.B.E.W.
WELFARE PLAN

SUMMARY PLAN DESCRIPTION

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MAY 1, 2017

LOCAL UNION NO. 363 I.B.E.W. WELFARE PLAN

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TO: PARTICIPANTS IN THE I.B.E.W. LOCAL UNION NO. 363 WELFARE PLAN

FROM: TRUSTEES OF THE I.B.E.W. LOCAL UNION NO. 363 WELFARE PLAN

DATE: January 1, 2017

This booklet is intended to describe, fully, the several benefits of the plan as it is in effect on January 1, 2017. The booklet itself has four parts:

A. Questions and answers;

B. Description of benefits;

C. Claim procedure;

D. ERISA rights - this section of the booklet is required to be given to you under the terms of the Employee Retirement Income Security act of 1974 and contains many technical details of the plan intended to ensure that you will be able to enjoy all the rights to which you are entitled under the provisions of the plan; and

E. Technical details.

The purpose of the plan is to:

A. provide at least partial reimbursement of costs actually incurred by the covered employee (or any eligible covered dependents) for certain health care procedures;

B. provide a disability income benefit designed to satisfy your employer's obligation to provide you with New York State Disability Benefits Law protections; and

C. provide a lump sum death benefit to the beneficiary of a covered employee when upon death.

Because it is not intended that the plan duplicate reimbursement that you receive under certain other health care programs, no reimbursement will be made under this plan, for health care costs, if such costs are covered under any Worker's Compensation or Occupational Disease Law.

Further, reimbursement for health care costs will be integrated with Medicare, state "no-fault" benefits, and any coverage under any other employer-sponsored health care plans or health care plans provided under the auspices of an educational institution.

The daily operation of the plan is maintained by the personnel employed by the Trustees and

located in the Plan Office. You are encouraged to make use of the facilities of the Plan Office where you will find assistance in understanding your benefits and in complying with the requirements in order to achieve your benefits.

Since the last printing of this booklet a considerable number of changes have been made to your plan. It is in your interest and that of your family to familiarize yourself completely with this booklet. If, after having gone through the booklet thoroughly, you have any questions regarding the plan or its operation, please do not hesitate to contact the Plan Office. If your questions are not answered to your satisfaction by the staff, you may direct questions to the Trustees in writing.

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant.

Sincerely,

The Board of Trustees

TABLE OF CONTENTS

GLOSSARY OF PLAN TERMS

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Accident
This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Contract. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)
The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug
A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;

- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment
A **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification
The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory
A listing of all **network providers** serving the class of employees to which you belong. The contract holder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and

- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

Emergency Care
This means the treatment given in a **hospital**'s emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational
Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;

- device;
- procedure; or
- treatment.

that states that it is **experimental or investigational**, or for research purposes.

Generic Prescription Drug
A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H

Homebound
This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.

- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

Institutes of Quality® (IOQ)
Institutes of Quality® Bariatric Surgery facilities are a national network of health care facilities that are designated based on measures of clinical performance, access and efficiency for bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

Late Enrollee
This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

L.P.N.
A licensed practical or vocational nurse.

M

Mail Order Pharmacy
An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder
An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity
This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge
As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties

under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist
A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider
A health care provider or **pharmacy** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment
A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider
A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P

Payment Percentage
Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Payment Limit
- **Payment limit** is the maximum out-of-pocket amount you are responsible to pay for your **payment percentage** for **covered expenses** during your calendar year. Once you satisfy the **payment limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. The **payment** limit applies to both network and out-of-network benefits.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;

- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R

Recognized Charge
The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  – the 80th percentile of the Prevailing Charge Rate;
  for the Geographic Area where the service is furnished.
- For inpatient and outpatient charges of **hospitals** and other facilities:
  – 80% of the **Aetna** Facility Fee Schedule;
  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area, **Aetna** Facility Fee Schedule and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.
- **Aetna** Facility Fee Schedule: The schedule of rates developed by **Aetna** using **Aetna** data or experience for out-of-network facility services and supplies provided in the Geographic Area in which you receive the service or supply. **Aetna** reviews and, if necessary, adjusts this schedule periodically.

Important Note
Aetna periodically updates its systems with changes made to the **Aetna** Facility Fee Schedule and Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the schedule or rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)
This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).

- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.

- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

R.N.
A registered nurse.

Room and Board
Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorder**s.

- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs
Prescription drugs include **injectable**, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the **specialty care drug list**.

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Substance Abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.

- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)
Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U

Urgent Admission
A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition
This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W

Walk-in Clinic
Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for:

- treatment of unscheduled;
- non-emergency **illnesses;** and
- **Injuries;** and
- the administration of certain immunizations.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

IMPORTANT ASPECTS OF YOUR PLAN

- FAMILIARIZE YOURSELF WITH THE WHOLE BOOKLET.

- ALL BENEFITS MUST BE APPLIED FOR.

- MAKE SURE THAT THE PLAN OFFICE IS AWARE OF ALL YOUR DEPENDENTS AND YOUR CURRENT ADDRESS. YOU MUST UDPATE THIS INFORMATON WITH THE PLAN OFFICE AS NEEDED.

- MAKE SURE YOUR DEATH BENEFIT BENEFICIARY DESIGNATION IS UP TO DATE.

- ALL CLAIM FORMS MUST BE COMPLETELY FILLED IN; INCOMPLETE ONES WILL BE RETURNED AND MAY DELAY PROCESSING YOUR BENEFITS OR LEAD TO A BENEFIT DENIAL.

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the plan or insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant. This booklet describes the plan as it exists on January 1, 2017.

CAUTION

This booklet and the Plan Manager are authorized sources of plan information for you. The Trustees of the plan **have not empowered anyone else** to speak for them with regard to the health plan. No Employer, Union Representative, Supervisor or Shop Steward is authorized to interpret your rights under this plan.

COMMUNICATIONS

If you have a question about any aspect of your participation in the plan, you should, for your own permanent record, write to the Plan Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

PLAN CHANGE OR BENEFIT TERMINATION

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested upon retirement;
- are contingent upon the right of the Trustees to make modifications or terminate such benefits;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such modifications or termination right are not contingent on financial necessity.

The benefits and eligibility rules applicable to pensioners and their dependents have been established by the Trustees as part of an overall benefit program for participants. The right to amend or modify the eligibility rules and plan of benefits for pensioners and dependents is reserved by the Board of Trustees. The continuance of benefits for pensioners and their dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Board of Trustees in accordance with their responsibilities and authority.

In accordance with the rules and regulations of the plan and the Trust Agreement, no employee or pensioner has a vested interest in the benefits provided for pensioners and their dependents. In addition to the right to terminate benefits of pensioners and/or their dependents at any time, in the event of termination of the health plan, the Trustees also reserve the right to terminate the plan of benefits for pensioners and there shall not be any vested right by any pensioner or dependent or beneficiary or contractual rights after the disposition of all plan assets and the termination of the plan. Pensioners and their dependents shall have no priority with respect to the disposition of plan assets in connection with the termination of this plan.

The plan gives the Trustees full discretion and authority to make the final decision regarding all areas of plan interpretation and administration including:

1. eligibility for benefits;

2. the level of benefits provided;

3. interpretation of plan language (including this summary plan description); and

4. administrative procedures.

PART A.

QUESTIONS AND ANSWERS

FINANCING

A most important element of your plan is money. Where it comes from, how it is managed, and to what uses it may be put should be of interest to you.

1. Who pays for the plan?

The employers who have collective bargaining agreements with Local 363 or agreements directly with the Trustees that call for contributions to the plan are the chief sources of contributions to the plan. In addition, there are certain other plans in other geographical areas with which this plan has reciprocal agreements. If you work in the jurisdiction of one of these other plans in employment covered by the other plan, certain contributions are required to be made by the other plan to this plan.

Active Members
Once you become eligible for coverage under the Plan as an active member, you are also required to contribute $100 per month to maintain coverage.

Retirees/Retiree Spouses/Beneficiaries (Pre 65)
Costs for Retirees and/or Retirees Spouses, and beneficiaries who are not enrolled in Medicare Advantage will be charged as follows:

Retirees/beneficiaries……COBRA Rate
With Spouse……COBRA +1 Rate
With Spouse/Family……...COBRA +1 Family Rate

Costs for spouses, who are not enrolled in Medicare Advantage and married to a Medicare Advantage enrolled Retirees will be charged as follows:

Spouse only……..COBRA Rate
Spouse/Family……COBRA + Family Rate

The COBRA Rates may vary year to year. The updated COBRA rates can be obtained through

the Plan Office. Updated COBRA rates will also be mailed to you annually.

2. How are the plan moneys managed?

All of the plan assets are held in trust by the Board of Trustees of the plan for the participants and beneficiaries of the plan. The Board of Trustees has the ultimate responsibility for the management of plan moneys.

3. May I pledge the claim money owing me for the purpose of obtaining a loan?

No. No benefits under the plan shall in any extent be assignable or transferable to the participant, except that assignment to a provider of the health services causing the claim is permitted.

4. If the plan is discontinued, what will happen to the assets of the plan?

The assets of the plan must be used for the benefit of the participants and beneficiaries only. If all the plan benefits are provided by the assets of the plan, and there is still money left over, the money may be used to provide benefits. Under no circumstances may money which has been properly contributed to the plan ever be returned to any employer or to Local 363.

ELIGIBILITY REQUIREMENTS

INITIAL COVERAGE

A qualifying period of service is required before you become covered in the plan. Being covered entitles you to receive certain documents explaining the plan and reports dealing with the plan's operation. You should be interested in how you become a participant, how your coverage is continued, and how your coverage will stop.

5. What is covered employment?

Covered employment means work for which your employer is required to contribute to the welfare plan either because of a collective bargaining agreement or because there is a special agreement with the plan Trustees.

6. Does self-employment count?

No. Under no circumstances will you receive any credit, for any purpose, under the plan for self-employment.

7. Suppose my employer (or I) wish to contribute to the welfare plan for me, even though my employer is not required to do so in a collective bargaining agreement, is it allowed?

No. Unless it is covered in a written agreement between your employer and Local 363, or between your employer and the plan Trustees, no credit can be given to you (even if your employer, or you, contributes to the plan) for any work you do.

8. How do I become covered in the plan?

When you work at least 1200 hours of covered employment during a period of 12 consecutive calendar months (you must work at least one hour in the first month of the period but you do not have to work in each month), you will become covered in the plan on the first day of the month after the 12 months. You will be permitted to earn hours in covered employment (toward the 1200 hours) by your own self-payment provided you have worked at least 400 hours (for a contributing contractor) toward the 1200 hours. Such self-payment must be made on a weekly basis and must be continuous.

As an example, suppose you started working in covered employment in June, 2011, and completed 1200 hours of covered employment by April, 2016. You have completed the hours' requirement (at least 1200) and by the end of June, 2016, you would have completed the months' requirement (12 months). The date your coverage starts is July 1, 2016.

"Covered" means you are covered under the plan for the benefits that apply to your classification.

As a condition of remaining Covered under the Plan you will also be required to contribute $100 per month in order to remain Covered.

9. Must I be available for work to remain a participant?

Yes. If you are not available for work and do not have a NYS Disability Determination or other Disability Determination provided by the state jurisdiction in which you were last referred by the IBEW Local 363 for work in covered employment when your coverage is scheduled to start, you will not be covered and you must satisfy the requirements for initial coverage all over again. If you are sick or injured, you will become covered on the first day of the month following the month you recover.

10. When I first become covered, for how long am I covered?

You will be covered for the balance of the calendar year in which you first become covered provided that you continue to contribute $100 per month.

MAINTAINING COVERAGE

11. Once I am covered, how does my coverage continue?

At the end of your initial period of coverage your record of covered employment will be reviewed to see if your coverage will continue for the next calendar year. The same review will take place at the start of each calendar year while you are covered.

You will continue to be covered for a calendar year provided you earned at least 1200 hours of covered employment during the immediately preceding calendar year and you contribute $100 per month in order to remain covered.

If you did not work the minimum number of hours required in a calendar year, your coverage in the plan will stop at the end of that calendar year. There is an exception if you are sick or hurt and have a NYS Disability Determination or other Disability Determination provided by the state jurisdiction in which you were last referred by the Union for work.

RECIPROCITY

12. What is reciprocity and how does it affect the plan?

This welfare plan will have arrangements ("reciprocity agreements") with certain other welfare plans, from time to time, that call for interchange of contributions when the members of one affected bargaining unit work in the jurisdiction of other bargaining units. In general, under such an arrangement, the employee will be credited in the employee's "home plan" with the hours of work the employee performs in the "away plan" when the employee travels and works in covered employment in the "away plan" area.

13. When will my coverage stop? Your coverage will stop due to one or more of the following events:

You do not earn 1200 hours in covered employment in a calendar year (your coverage will continue until the end of the calendar year, provided you continue to pay your monthly contribution).

You do not contribute $100 per month by the beginning of the month that it is due, regardless if you earned 1200 hours.

If you enter the military service, while covered, your coverage will stop immediately upon such entry. When you return from such service, you should contact the Plan Office to see about any special veteran's reinstatement privilege.

If you become unavailable for covered employment for a reason other than providing proof of a NYS Disability Determination or other Disability Determination provided by the state jurisdiction in which you were last referred by the Union for work, your coverage will stop immediately.

14. What if I waive my right to coverage?

If you decline to pay the contribution of $100 per month because you have other health coverage available to you (for example, your spouse's coverage), you will no longer be considered a Participant under the Plan. However, you may be eligible for reinstatement if you satisfy the following conditions:

1. You earn 1200 hours in covered employment during the immediately preceding

calendar year in accordance with the eligibility rules set forth in section 8 of this Plan; and

2. You and your spouse lose eligibility for the other coverage (or if the employer stops contributing toward your dependent spouse's other coverage) that was selected in lieu of coverage under the I.B.E.W. Local 363 Welfare Plan; or
3. You have a new dependent as a result of marriage, birth, adoption, or placement for adoption (in which case you may enroll with dependents).

If one of these events occurs, you will be required to request reinstatement within thirty (30) days after the other coverage ends or as a result of marriage, birth, adoption or placement for adoption. You will be required to provide proof of loss of coverage (present the certificate of creditable coverage from the health plan in which you lost coverage) or marriage, birth or adoption certificate.

If you decline overage, the period in which you are not enrolled in the Fund will not count toward your eligibility for pensioner coverage. Eligibility for Pensioner coverage is subject to section 27 of the Plan.

15. Is there any special consideration given for total disability?

If you become totally disabled while you are covered (in a period of coverage that has lasted at least two consecutive years) and such total disability lasts for at least seven consecutive days, your account will be credited with eight hours per work day (Monday through Friday) during which you are totally disabled.

To be considered totally disabled you must not be able to work for wage or profit.

For any one period of disability (or related disability) you will not be given such credits for any day that is more than one year after the start of your disability. If you have been covered for at least six consecutive years at the time you became disabled, you can receive such credit for up to two years.

16. Is there any time I may be provided coverage even if I do not earn 1200 hours in covered employment?

At the discretion of the Trustees if certain economic circumstances occur that may be beyond the members' control that result in the inability to earn 1200 hours in covered employment, you may be granted additional credited hours. If this is the case, you will be notified by the Trustees. You will still be required to pay $100 per month contribution if you are granted the coverage or any other amount as set forth by the Trustees.

REINSTATEMENT

17. How will my coverage be reinstated once it has stopped?

Notwithstanding any provisions to the contrary, you must once again satisfy the eligibility requirements for initial coverage. See question 8.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

18. If my coverage is terminated, may I continue it by self-payment?

Yes. You will be entitled to continue your coverage on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

19. What is COBRA?

The law requires the plan to offer temporary continuation of health coverage, in certain instances when coverage would end, at group rates.

20. Which employees are eligible for COBRA continuation coverage?

As a member covered by the plan, you may choose to continue coverage, by self-payment, if you lose coverage due to a reduction in your employment hours or because your employment terminates. You can maintain coverage, by self-payment, for up to 18 months. Coverage can be maintained for up to 29 months if you are disabled under Title II or XVI of the Social Security Act at the time employment ended or your work hours were reduced or during the first 60 days of COBRA coverage.

21. When is my spouse eligible for COBRA continuation coverage?

Your spouse covered by the plan may choose continuation if health coverage is lost due to any of the following events:

1. your death;

2. the termination of your coverage because of a termination of employment or a reduction in employment hours; or

3. divorce or legal separation.

A spouse can maintain coverage for up to 36 months, by self-payment, unless the loss was due to termination of employment or reduction in employment hours of the employee. In this case, coverage can be maintained for 18 months. If the employee is entitled to Medicare at the time of termination of employment or a reduction in employment hours, the spouse can maintain coverage for 36 months.

22. When does my dependent child become eligible for COBRA continuation coverage?

Your dependent child may continue coverage if coverage would be lost due to any of the following events:

1. your death;

2. your termination of employment or a reduction in the parent's hours of employment;

3. divorce or legal separation of you and your spouse;

4. your eligibility for Medicare; or

5. the child's loss of status as a child as defined by the plan.

A dependent child can maintain coverage for up to 36 months, by self-payment, unless the loss was due to termination of employment or reduction in employment hours of the employee. In this case, coverage can be maintained for 18 months. If the employee is entitled to Medicare at the time of termination of employment or a reduction in employment hours, the dependent child can maintain coverage for 36 months.

23. How is a person eligible for COBRA continuation coverage notified of his or her eligibility?

Your employer has the obligation to notify the Plan Office of your death or your eligibility for Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates. You, your spouse, or one of your dependent children who is eligible for COBRA continuation coverage has the obligation to notify the Plan Office of your divorce, legal separation or your child's loss of status and eligible dependent. This notice must be given within 60 days after the occurrence of the event.

After the Plan Office receives notice of the occurrence of the above events, it will notify each eligible individual of his or her right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Plan Office will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the events described above or within 14 days after determining that your regular group health care coverage has terminated.

24. When must election be made?

Any person eligible for COBRA continuation coverage will have a period of at least 60 days from the date he or she would otherwise lose coverage under the plan to advise the Plan Office that he or she wants COBRA continuation coverage. The request for continuation of coverage must be in writing, on a form provided by the Plan Office.

Coverage will be continued provided that:

1. the election form is duly completed and returned to the Plan Office within the 60-day period noted above; and

2. the required payment is paid to the Plan Office within 45 days of your or your dependent's written request for continuation of coverage.

Newborns And Adoptees

A child who is born to or placed for adoption with a covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the plan and the requirements of federal law, these qualified beneficiaries can be added to the COBRA coverage upon written notification to the Plan Office of the birth or adoption.

25. What type of benefits are available for COBRA continuation coverage?

The benefits an eligible individual is allowed to elect to receive will include all health benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance, accidental death or dismemberment, disability or other non-health benefits will be included. An eligible individual may elect to receive the same benefits he or she had been receiving or he or she may elect to receive only "core" benefits, which excludes the dental and vision benefit provided by the plan to other participants.

26. How long does COBRA continuation last?

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended unless you were disabled under Title II or XVI of the Social Security Act at the time your employment terminated. In that case, you are entitled to purchase a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. the employer ceases to provide group health coverage to any of its employees;

2. failure to pay the monthly premium in a timely fashion;

3. you become covered under another group health plan (if that plan does not include any pre-existing condition limitation or exclusion);

4. you become eligible for Medicare; or

5. circumstances are such that the individual's participation could be cancelled if the individual were an active employee.

27. What is the cost of COBRA continuation coverage and how is the cost computed?

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Plan Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the

average annual per participant cost incurred by the plan.

FAMILY AND MEDICAL LEAVE ACT

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

- to care for your newly born or adopted child;
- to care for your spouse, child or parent who has a serious health care problem; or
- if you have a serious health problem which prevents you from performing your job.

In order for you to be eligible for such leave, your employer must have been obligated to make contributions to the plan on your behalf for at least 1,200 hours in the preceding 12-month period. You must also have worked for that employer for at least 12 months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an employer must have at least 50 employees for each working day for each of 20 work weeks in the current or preceding calendar year. Additionally, you must:

- work at a location where the employer has at least 50 employees; or
- work within 75 miles of one or more work sites where the employer has 50 or more employees.

Your employer must notify the Plan Office that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance reports to the plan, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act to a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the plan just as if your employment had not stopped, unless your employer fails to make the required contributions for you. Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your covered dependents, the same as to eligible employees and their covered dependents. If you do not return to covered employment after your leave ends, you are entitled to COBRA continuation coverage when your leave ends. Call your employer to determine whether you are eligible for FMLA leave. Call the Plan Office regarding coverage during FMLA leave.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

- your employer fails for any reason to make the required contributions to the plan on your behalf while you are on leave;

- you exhaust the 12 weeks of leave which you are entitled to under the Act; or

- you or your employer notifies the Plan Office that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave.)

In the event your employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with the provision of the section of this summary plan description on page 3.

MILITARY LEAVE OF ABSENCE THROUGH THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you are on military leave of absence as a result of entering the uniformed services of any country (active duty or inactive duty training), you medical, prescription drug, may continue in accordance with your collective bargaining agreement and under the provisions of USERRA. If your military service extends beyond the time limit specified by your collective bargaining agreement, you and/or your dependents may be eligible to continue coverage under COBRA or insurance continuation by paying the applicable cost.

Military Leave

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

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

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

a. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
b. If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan that leave period.

Duty to Notify the Plan

The Plan will offer the employee USERRA continuation coverage only after the Plan Manager has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Manager as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage

Once the Plan Manager receives the notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA. Note that USERRA is an alternative to COBRA. Therefore, either COBRA or USERRA can be elected and that coverage will run simultaneously, not consecutively.

Paying for USERRA Coverage

c. If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under the Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.
d. If the employee elects USERRA coverage, the employee (and any eligible dependents coverage under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like COBRA. See the COBRA Section for details.

In addition to USERRA or COBRA, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE.

After Discharge from the Armed Forces

When the employee is discharged from military service (not less than honorably), eligibility will be reinstate on the day the employee returns to work provided the employee returns to employment within:

e. 90 days from the date of discharge from the military if the period of services was more than 180 days; or

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

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

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

If you have any questions about taking a leave of absence, please speak directly with your employer. If you have any questions, about how a leave of absence affects your coverage, please contact the Plan Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

DEPENDENTS

28. Who are my eligible dependents for purposes of this plan?

For the purpose of declaring a dependent eligible under the plan, "Child" means your natural child, a child adopted by you or a child for whom adoption proceedings have been instituted, and a child for whom you have been appointed the legal guardian of the person and property.

An eligible dependent includes children up to the end of the month in which you turn age 26, whether married or unmarried, and regardless of student status, financial dependency on the participant, or any other factor other than the relationship between the child and the participant.

Federal law requires the plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce. The details of these requirements are summarized below. Be sure you read them carefully.

The process begins when the Plan Office receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decrees, or order, including approval of a settlement agreement, which:

1. issues from a court of competent jurisdiction pursuant to a state's domestic relations law;

2. requires you to provide only the health coverage available under the plan for your children, even though you no longer have custody; and

3. clearly specifies:

a. your name and last known mailing address and the names and addresses of each child covered by the order,

b. a reasonable description of the coverage to be provided,

c. the length of time the order applies, and

d. each plan affected by the order.

The Plan Office will provide written notification to you and each identified child that it has received a court order requiring coverage.

If the QMCSO meets the above requirements, the Plan Office will provide written notification to you and each affected child of his or her eligibility for coverage. This notice will include any required enrollment material, a description of the procedures to be followed, and a form for designating the child's custodial parent or legal guardian as his or her representative for all plan purposes.

If the Plan Office receives a valid QMCSO, it must permit immediate enrollment or upon such a date specified by the QMCSO. This means the children identified will be included for coverage as your eligible dependents. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you don't.

If you have any questions about any of these requirements, contact the Plan Office.

Dependent also includes your Spouse, whether of the opposite or same sex. If you are claiming your same-sex spouse as a dependent, you must submit proof of marriage from the state in which the ceremony occurred. Your same-sex spousal dependent will be eligible for enrollment in the Plan on the date that the Plan Office validates such proof of marriage.

When are my dependents eligible for coverage under the plan?

In general, your eligible dependents will be covered in the plan during the same period of time that you are covered.

29. For what benefits are my dependents covered?

In general, they will be covered by the same benefits as you. There are some differences, however. For example, only you are covered for death benefits. You may wish to contact the Fund Office for additional clarification.

30. When does coverage for my dependents stop?

Their coverage stops when your coverage stops. If a dependent stops being an eligible dependent, the dependent's coverage will stop even if your coverage does not stop. For example, if you and your covered spouse divorce, your spouse's coverage would stop even though yours might continue. If your covered child reaches age 26, your covered child's coverage would stop even though yours might continue.

31. If I die while I am covered, what will happen to the coverage of my dependents?

The coverage of any of your dependents who were covered in the plan at your death will continue after the date of your death. If your dependent stops being eligible for coverage for another reason (such as a child becoming age 26 or being eligible for coverage through his or her employer), your dependent's coverage will stop. If a surviving spouse remarries during the coverage period, the surviving spouse's coverage will stop.

PENSIONERS

32. Are pensioners covered under the plan?

If a pensioner (other than a surviving spouse or beneficiary) under the I.B.E.W. Local 363 Pension Plan was covered under this plan for at least ten (10) consecutive calendar years immediately preceding the effective date of retirement, the pensioner will be covered as a pensioner in the welfare plan.

An employee who becomes a pensioner participant in the welfare plan will be covered for pensioner's benefits under the welfare plan beginning with the effective date of pension.

33. When does the coverage of a pensioner stop?

If the pension payments of a pensioner participant stop, the pensioner will continue to be covered under the welfare plan as a pensioner until either becoming entitled to coverage as an active employee because of work in covered employment after pension payments stop or reaching the end of the period during which coverage would have been continued as the result of work before retiring if the period of time during which the pensioner was receiving a pension were disregarded, whichever occurs first.

Also, if you do not pay the required monthly contribution payment by the first of the month, you will lose coverage.

34. What benefits apply to a pensioner?

There is a special plan of benefits that apply to pensioners. These benefits (as well as those for employees) are outlined in the "Summary of Benefits" in Part B. of this booklet.

35. Are the dependents of a pensioner also covered?

If you are covered as a pensioner in the plan, your eligible dependents are covered in the same way that the eligible dependents of an employee are covered, except that a different plan of benefits apply.

36. Required Contribution for pensioners covered under the Aetna Medicare Advantage Plan.

You will be charged the full negotiated premium for medical and prescription in the Fund's Aetna Medicare Advantage Plan.

37. Contribution requirements for pensioners between ages 55-65.

If you are a pensioner between the ages of 55-65 (not an Aetna Medicare Advantage Plan participant) you will be required to pay a monthly contribution based upon 100% of the COBRA premium set forth by the actuaries of the Plan that were adopted by the Trustees. This contribution requirement may be adjusted by the Trustees at their discretion.

38. Contribution requirements for spouses of deceased members who are Covered under the Plan.

Spouses of deceased members who are covered under the Plan shall pay a monthly contribution based on their status (Medicare or non-Medicare eligible) to remain covered under the Plan.

39. Conditions in which you may be reinstated for coverage in the event that you decide not to continue participation in the Plan.

If you decline coverage because of your health insurance or group health plan coverage in which you are eligible, you may be eligible for reinstatement solely due to the following events:

a. You or your dependent spouse lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependent's spouse's other coverage);
b. You have a new dependent as a result of marriage, birth, adoption, or placement for adoption (in which case you may enroll with dependents).

You will be required to request reinstatement within thirty (30) days after the other coverage ends or as a result of marriage, birth, adoption or placement for adoption.

PART B.

BENEFITS

INTRODUCTION

There are several benefits in the plan, with different conditions and maximum amounts associated with each benefit. Further, not all classes of covered persons are entitled to the protection of the same benefits.

The purpose of this part of the booklet is to describe the various benefits and let you know which classes of participants are covered for which benefits.

Note that there is reimbursement allowed in the event of the death of the covered employee and pensioner, as well as allowances for the reasonable costs for certain health care procedures. Some benefits are limited to active participating employees and covered dependents.

CLASS OF COVERED PERSON

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

BENEFIT	EMPLOYEE	EMPLOYEE'S DEPENDENTS	PENSIONER	PENSIONER'S DEPENDENTS
Death	Yes	No	Yes	No
Disability Income	Yes	No	No	No
Hospital	Yes	Yes	Yes	Yes
Surgical	Yes	Yes	Yes	Yes
Diagnostic	Yes	Yes	Yes	Yes
Doctor Treatment	Yes	Yes	Yes	Yes
Major Medical	Yes	Yes	Yes	Yes
Special Care	Yes	Yes	Yes	Yes
Dental Care	Yes	Yes	Yes	Yes
Vision Care	Yes	Yes	Yes	Yes
Prescription Drug	Yes	Yes	Yes	Yes
Chiropractic	Yes	Yes	Yes	Yes
Well-Baby Care	Yes	Yes	Yes	Yes

SCHEDULE OF MEDICAL BENEFITS

GENERAL PROVISIONS

Dependents Eligibility — **Spouse, children from birth to end of month in which child turns age 26**

Pre-existing Conditions Exclusion — On effective date: Waived

After effective date: Waived

Expenses That Do Not Apply to Your Payment Limit
Certain covered expenses do not apply toward your plan payment limit. These include:

- Charges over the **recognized charge**;
- Expenses applied toward a **copayment for out of network**;
- Any **covered expenses** which are payable by **Aetna** at 50%,
- Expenses incurred for outpatient treatments, including any outpatient **prescription drugs**, **mental disorder** treatment expenses, **substance abuse** and alcoholism treatment expenses;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

There is no Maximum Benefit Limitation (Annual or Lifetime) for Essential Health Care Benefits as defined by the Patient Protection and Affordable Care Act of 2010.

Precertification Program

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $200 benefit reduction will be applied separately to each type of expense.

40. Are there any limitations on the coverage for health care expenses?

Yes. Coverage is limited to certain maximum amounts and there are other limitations, as explained in the benefit section of this booklet.

Only reasonable charges will be considered; the excessive part of any charge will not be covered.

Expenses incurred without the direction of a doctor or dentist are not covered.

Further, only charges incurred <u>while</u> the patient is covered under the Plan will be considered for coverage.

41. Are hospital charges covered regardless of the type of hospital involved?

No. Only the charges of an institution that has all the following characteristics will be considered:

a. it holds a license as a legally qualified hospital;

b. it operates primarily for the reception, care and treatment of sick, ailing, or injured persons as inpatients;

c. it provides 24-hour nursing service by licensed, registered, graduate nurses;

d. it has a staff of at least one licensed physician and surgeon available at all times;

e. it provides organized facilities for diagnosis and surgery; and

f. it is not, primarily, a clinic, nursing, rest, or convalescent home similar establishment nor a place, primarily, for alcoholics or drug addicts.

PLAN FEATURES	**IN NETWORK**	**OUT OF NETWORK**
Deductible (per calendar year)	$0 Individual $0 Family	$500 Individual $1000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Payment Limit (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Only those non-preferred expenses resulting from the application of coinsurance percentage (except out of network copays, and penalty amounts) may be used to satisfy the Payment Limit.		
Lifetime Maximum *Except where otherwise indicated	Unlimited*	Unlimited*
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements – Certification for certain types of Out of Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admission, Treatment Facility Admiisssions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required – excluded amount applied separately to each type of expense is $200 per occurrence.		
Referral Requirement	None	None

PREVENTIVE CARE	IN-NETWORK	OUT OF NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older	Covered 100%	Not Covered
Routine Well Child Exams/ Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 22.	Covered 100%	50% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%	Not Covered
Routine Mammograms For covered females age 40 and over.	Covered 100%	40% after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%	Member cost sharing is based on the type of service performed and The place of service where it is rendered after deductible
Routing Digital Rectal Exam/ Prostate specific Antigen Test For covered males age 40 and over	Covered 100%	40% after deductible
Colorectal Cancer Screening For all members age 50 and over	Covered 100%	Member cost sharing is based on the type of service pefomred and the place of serivce where it is rendered; after deductible
Routine Hearing Exams 1 routine exam per 24 months	$50 office visit copay	40% after deductible

PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK

Office Visits to PCP	$35 office visit copay	40% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 office visit copay	40% after deductible
Pre-Natal Maternity	Covered 100%	40% after deductible
Allergy Testing	$50 copay	40% after deuctible
Allergy Injections	$50 copay	40% after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT OF NETWORK**
Diagnostic Laboratory and X-Ray	$50 copay	40% afer deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT OF NETWORK**
Urgent Care Provider (benefit availability may vary by location)	**$35 copay**	**$35 copay**
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$100 copay	$100 copay
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT OF NETWORK**
Inpatient Coverage waived	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a members's inpatient stay		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20% after deductible	40% after deductible

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	20% after deductible	40% after deductible
Outpatient Surgery (Freestanding Facility)	20% after deductible	40% after deductible
Outpatient Hospital Expenses (Excluding surgery)	20% after deductible	40% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		

MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT OF NETWORK**
Inpatient	Covered same as Inpatient Hospital Services	Covered Same as Inpatient Hospital Services
The member cost sharing applies to allcovered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		

ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT OF NETWORK**
Inpatient	Covered same As Inpatient Hospital Services	Covered same as Inpatient Hospital Services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible

The members cost sharing applies to all Covered Benefits incurred during a member's outpatient visit.

OTHER SERVICES	IN-NETWORK	OUT OF NETWORK
Convalescent Facility (skilled nursing)	20% after deductible	40% after deductible
Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.		
Home Health Care Limited to 30 visits per calendar year. Each visit by a nurse or therapis is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% after deductible	40% afer deductible
Hospice Care – Inpatient Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	40% after deductible
Hospice Care – Outpatient	20% after deductible	40% after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, limited to 60 visits combined per calendar year.	$50 copay	40% after deductible
Spinal Manipulation Therapy Limited to $1,400 per calendar year.	$50 copay	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Diabetic Supplies	Covered same as Any other medical expense	Covered same as Any other Medical expense
Contraceptive drugs and Devices not obtainable at a Pharmacy	100%	Not covered
Generic FDA-approved Women's Contraceptives	Covered 100%	Not Covered

Transplants	Covered 20% after Deductible. Preferred Coverage is provided at At an IOE contracted Facility only	40% after deductible. Non-Preferred coverage is provided at a Non-IOE facility after deductible
Bariatric	20% after decuctible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a members' inpatient stay.		
Mouth, Jaws and Teeth (oral surgery procedures, Whether medical or dental In nature)	Member cost sharing is Based on the type of Service performed and The place of service where It is rendered	40% after deductible
Out of Area Dependents	Coverage provided at the out of network benefit level of the plan.	

FAMILY PLANNING	**IN-NETWORK**	**OUT OF NETWORK**
Infertility Treatment	Member cost sharing Is based on the type of service performed And the place of service Where it is rendered; After deductible	Member cost sharing is based on the type of serivce performed and the place of service where it is rendered; after deductible.
Diagnosis and treatment of the underlying medical conditiion		
Vasectomy	Member cost sharing is Based on the type of Service performed And the place of service Where it is rendered; after Deductible	Member cost sharing is based on the type of service performed the place of serivce where it is rendered; after deductible
Tubal Ligation	Covered 100%	Member cost sharing

	Is based on the type Of service performed And the place of service where it is rendered after deductible

GENERAL PROVISIONS

Dependents Eligility	Spouse, children from birth to end of month in which they reach age 26.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

The plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to this plan to determine which health care services are specifically covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, there may be exceptions according to the above, based on state mandates or plan design:

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered by this Plan; nonmedically necessary services or supplies; Orthotics; over the counter medications and supplies; Reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, to the extent not specifically covered above.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

Wellness

This section on Wellness describes the **covered expenses** for services and supplies provided when you are well. Refer to the *Schedule of Benefits* for the frequency limits that apply to these services, if not shown below.

Covered expenses for children from birth through age 6 also include:

- An initial **hospital** checkup and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, payment percentage, benefit maximums and frequency and age limits for physical exams.

Routine Cancer Screenings
Covered expenses include charges incurred for routine cancer screening as follows:

- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 12 months.

Family Planning Services
Covered expenses include charges for certain family planning services, even though not provided to treat an **illness** or **injury**. Refer to the *Schedule of Benefits* for the frequency limits that apply to these services, if not specified below.

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Also see section on pregnancy and infertility related expenses on a later page.

Hearing Exam
Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All **covered expenses** for the routine hearing exam are subject to any applicable **deductible**, **copay** and **payment percentage** shown in your *Schedule of Benefits*.

Physician Services

Physician Visits
Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment or travel,
- Allergy testing and allergy injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Surgery
Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board
Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses
Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders
The plan will only pay for nursing services provided by the **hospital** as part of its charge.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**. **Covered expenses** for these charges are payable at the out-of-network benefit level if the provider has not contracted with **Aetna**, even if the facility is in the **Aetna** network.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **payment percentage** and maximum benefit limits.

Coverage for Emergency Medical Conditions
Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment for an **emergency medical condition**.

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions
Covered expenses include charges made by an **urgent care provider** to evaluate and treat an urgent condition.

Your coverage includes:

- Use of urgent care facilities;

- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment of an urgent condition.

If you visit an **urgent care provider** for a non-urgent condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services
Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- An office-based surgical facility of a **physician** or **dentist**;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician**'s or **dentist's** office.

Important Note
Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations
Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Birthing Center
Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations
Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care
Covered expenses include charges made by a **home health care agency** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- Medical supplies, **prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had continued your **hospital stay**.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are not met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Therapy Services section.

Limitations
Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders
The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Skilled Nursing Facility
Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room** and **board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;

- Radiological services and lab work;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *Using Your Medical Plan* for details about **precertification**.

Limitations
Unless specified above, *not* covered under the Skilled Nursing Facility are charges made for the treatment of the following:

- Charges made for the treatment of:
  - Senility;
  - Mental handicap; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi-private rate**.

Hospice Care
Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:

  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies.
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;

A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Limitations
Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Important Reminders
Refer to the *Schedule of Benefits* for details about **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses

Acupuncture
The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service
Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance
Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; ***and*** the two conditions above are met.

Limitations
Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

Diagnostic and Preoperative Testing

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services other than diagnostic complex imaging, lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductible, payment percentage** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder
Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria;
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for one post-delivery home visits by a health care provider.

Covered expenses for a **birthing center** are described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.
The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;

- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Short-Term Rehabilitation Therapy Services

Covered expenses included charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed

to develop physical function.

- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.
Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from: illness; **injury**; or congenital defect;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Services provided by a **physician** or physical, occupational or speech therapist who

resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.
  Note: Injuries that occur as a result of a medical (*i.e.*, non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
- the defect results in severe facial disfigurement, or
- the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery as a Result of Mastectomy

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits.*

Specialized Care

Chemotherapy
Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits
Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits
Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible**, **payment percentage** and maximum benefit limits.

Treatment of Infertility

Basic Infertility Expenses
Covered expenses include charges made by a **network physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**;
- For treatment of scoliosis;
- For fracture care; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the **IOE** facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations
Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Services and supplies furnished by a non-**IOE** facility;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities
Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Obesity Treatment

Covered expenses include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam.

Covered expenses include one **morbid obesity** surgical procedure, within a two-year period, beginning with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned.

But only when you have a:

- **Body mass index** (BMI) exceeding 40; or
- BMI greater than 35 in conjunction with any of the following co-morbidities any one of which is aggravated by the obesity:
  - Coronary heart disease;
  - Type 2 diabetes mellitus;
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management.

Limitations
Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this *Booklet*.

Important Reminder
Refer to the *Schedule of Benefits* for information about any applicable benefit maximums that apply to **morbid obesity** treatment.

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **behavioral health providers**.

Important Notice
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Health Plan Exclusions and Limits* section for more information.

Treatment of Mental Disorders
Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment
Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment
Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment
Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for more information about **precertification**.

Alcoholism and Substance Abuse
Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers.** In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse.**

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse
The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of alcoholism or **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital**, when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse
The plan covers outpatient treatment of alcoholism or **substance abuse**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse
Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay**

if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the **injury**.

Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- Accidental **injuries** and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place no later than 24 months after the **injury**.

Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.

If a child needs oral surgery as the result of accidental **injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.

Note: Trauma which occurs as a result of biting or chewing is *not* considered accidental **injury**, even if it is unplanned or unexpected.

Pathology

- The plan covers removal of tumors and cysts requiring pathological examination.

Radiation Treatment

- The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Anatomical Defects

- The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

Related Dental Services Are Limited To:

- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to preposition teeth.

Dental implants are *not* covered.

PRESCRIPTION DRUG BENEFIT

Description

The prescription drug benefit provided to a covered person is administered by ExpressScripts Health Services. When a covered person incurs expenses for the dispensing of a drug, covered by this benefit, which was prescribed in written form, by a doctor, and is filled by a participating pharmacy, the plan will pay a portion of the cost of such drug.

Copay

You will continue to pay a portion of the cost, your copay, of any medicine you purchase. You

will pay the following copay.

Copays At Local Retail Pharmacy (30 day Supply)	
Copay:	Minimum copay: $25. Maximum copay: $40.

Copay when purchasing a brand with generic equivalent (see Mandatory Generic Program Section)

Copays At Mail Service Pharmacy (90 Day Supply)	
Brand	$50.
Generic	$80.

Copay when purchasing a brand with generic equivalent (see Mandatory Generic Program Section)

Mandatory Generic Program

When purchasing a brand medicine that has a generic equivalent available the member pay amount is equal to the generic copay plus the Ancillary charge. Ancillary charge is the difference between the cost of the brand and the generic medicine. You may pay more than $25 in this instance.

Proton Pump Inhibitors And Non-Sedating Antihistamines

The retail and mail order co-pays for Non-Sedating Antihistamines (allergy meds) and Proton Pump Inhibitors (gastric meds), where there is an "over the counter' equivalent, will be increased to $50 at retail and $100 for mail-order. Following are examples of these prescriptions:

PPI	Over-the-Counter Equivalent
Nexium	Prilosec
Prevacid	Prilosec
Protonix	Prilosec

Non-Sedating Antihistamines	Over-the Counter Equivalent
Allegra	Claritin
Zyrtec	Claritin
Clarinex	Claritin

Coordination Of Benefits

The plan will now track in the pharmacy system your eligible dependents that have primary pharmacy coverage with another benefit plan. These dependents will be coded as being primary under another benefit plan and will be considered to have secondary coverage under the I.B.E.W. 363 plan. They will be required to use their primary pharmacy coverage plan first.

Eligible dependents with secondary coverage may file a paper claim to be reimbursed for any

benefits they are entitled to after the subtracting the copay.

Too Soon To Refill Edit

The plan will add a "too soon to refill" edit of 75%. This means you will have to wait until you have used 75% of the day supply of your prescription before you fill it at your local retail pharmacy. Prescriptions filled for 30 days can be refilled on the 23rd day.

Formulary

A formulary is a list of medicines that are preferred for use because of their safety, quality, effectiveness and cost. Using a formulary does help your plan save money. You should review this list with your doctor to decide if a formulary medicine might be more effective then the medicine you are currently using. Only your doctor can decide which medicine is the most effective for you to use. You may call the ESI helpline at 800-287-0358 to find out if there are formulary alternatives for any drug you use.

Mail Pharmacy Service And Mandatory Use For Maintenance Medications

ExpressScripts will provide the mail pharmacy service.

Any member or dependent that uses maintenance medicines may fill each medicine up to three (3) times at their local retail pharmacy. After being filled three times at the local retail pharmacy, maintenance medicines must be purchased from the mail service pharmacy. Maintenance medicines are used for chronic conditions such as diabetes, high blood pressure, and heart conditions. Synthroid is an example of a maintenance medicine.

Advanced Therapeutic Intervention (ATI)

Advanced Therapeutic Intervention (ATI) program is a program that will identify patients at risk for potential health problems as a result of the medications they take. Some potential drug therapy problems are: two different doctors prescribing medicines for you that interact negatively with each other; taking dosages that exceed the recommended daily dosage for your condition; and taking dosages that are lower than recommended for your condition. All of these situations could negatively affect your healthcare and even lead to more serious health problems.

When a potential drug therapy problem is discovered, the physicians involved will be sent a letter describing your potential drug therapy problem and encouraged to make necessary changes in your therapy. However, it will be up to your doctors to decide what change to make in your current treatment.

This program is part of the fund's continuing effort to provide you with improved medical coverage. It will assist your doctor in providing you with quality health care.

Questions

You may call ExpressScripts help line to help you estimate what your copay will be on any medicine you use. This help line is available 24 hours a day, seven days a week. The help line

number is (800) 287-0358 and appears on the back of your pharmacy card.

DENTAL CARE BENEFIT

Expenses covered under any other health care benefit of the plan will not be covered under this benefit.

A. DESCRIPTION. When a covered person incurs expenses for dental services listed in the Local Union No. 363 I.B.E.W. Dental Schedule (copy in Plan Office) or for orthodontic treatment, such service being performed by a dentist while such person is covered under the plan will pay the actual expense incurred for such service, not to exceed the amount applicable to the service in such Schedule and in C.

B. PRE-DETERMINATION OF BENEFITS. Pre-determination of benefits is required if a proposed course of treatment is expected to involve charges of $500 or more.

Under the Dental Expense Benefit, services expected to exceed $500 must be pre-determined. "Pre-determination of benefits" is a system that allows you and your dentist to know, in advance, what estimated benefits would be payable for a proposed course of dental treatment.

Under the pre-determination of benefits, the dentist completes a Fund claim form and sends it to the address indicated on the claim form before any dental services are performed. The dentist may also complete an ADA claim form and forward it to the Plan Office. These forms must list the recommended dental services and must show the charge for each dental service. All requests for pre-determination will be reviewed by the Fund and returned to the dentist showing estimated benefits. The Fund reserves the right to request supporting pre-operative X-rays or other diagnostic records in connection with pre-determination of benefits.

In computing the estimated benefits, the Fund may consider alternate dental services that are suitable for care of a specific condition. This will be done only if those alternative services would produce a professional acceptable result, as determined by the Fund.

C. ORTHODONTIC TREATMENT. When a covered dependent child under 19 years of age incurs expense for the services of an orthodontist for the correction of:

1. overbite or overjet of at least four millimeters;

2. maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp; or

3. crossbite;

and such treatment commenced while the covered person was covered under the plan, the plan will pay the actual expense for such services as are performed while the covered person is covered and still under 19 years of age.
There is no coverage for orthodontic treatment under this benefit for any other person than a covered dependent child under 19 years of age.

The first $50 of charges for orthodontic treatment incurred by a covered person in a lifetime while covered under the plan is not an eligible expense under the plan.

To be considered for reimbursement under this subsection, expenses for orthodontic treatment must be contained in the treatment plan submitted (and described in B. above) which is accompanied by study models and a description of the course of treatment, and the duration of treatment, as well as the other details mentioned in B. above.

The total covered charges for the course of orthodontic treatment will be considered to be incurred on a quarterly (every three months) basis with the total charge divided on a quarterly basis over the estimated duration of the course of treatment. The first quarterly installment will be considered to be incurred upon the insertion of the orthodontic appliances.

The maximum amount payable, under this subsection, for all expenses relating to orthodontic treatment for any one covered person during a lifetime is $800.

D. MAXIMUM PAYMENT. The maximum amount payable, under this benefit, for all covered persons in the same family for all dental care expenses incurred in any one calendar year is $4,000. If a patient is transferred from one dentist to another in the course of treatment or if more than one dentists renders service on the dental procedure, the benefits will be determined just as though one dentist had furnished all treatment.

E. SOME DENTAL EXPENSES NOT REIMBURSABLE. No payment will be made under this benefit for expenses for:

1. Services or supplies (a) furnished by or for the U.S. Government, or (b) furnished by or any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.

2. Anything not ordered by a dentist; anything not necessary for dental care; or services deemed experimental or not accepted by the American Dental Association standards of dental practices; charges in excess of those usually made when there is no insurance/coverage or in excess of the general level in the area.

3. Expenses due to war (including undeclared war and armed aggression).

4. Expenses due to an accident related to employment or disease covered under Workers' Compensation or similar law.

5. Orthodontics (a program to straighten teeth, except as noted.) See Orthodontic Expense Benefit on page 72.

6. Expenses for crowns or appliances if made solely for periodontal involvement and to stabilize or splint mobile teeth.

7. Expenses for replacement of a lost prosthetic appliance.

8. Fees for the replacement of any full or partial dentures, fixed bridgework or crowns if benefits for these appliances had previously been provided under our Dental Plan unless five years have elapsed from the installation of any such appliances. This exclusion also applies to the replacement of a prosthetic appliance by a fixed bridgework within a five year period. However, if an immediate (temporary) denture, for which the charge was less than the allowance in the schedule, is replaced by a permanent denture within a five year period, the excess of the schedule allowance over the charge for the immediate (temporary) denture is available as reimbursement towards the charge for the permanent denture.
9. Fees for removable partial maxillary or mandibular replacement with a partial denture, unless three or more permanent teeth are missing from either the right or left quadrants of the maxilla or mandible.

10. Services and supplies solely for cosmetic purposes.

11. Services and supplies relating to dental implants.

Additionally, all General Plan Exclusions apply to your dental benefit.

VISION CARE BENEFIT

A. MAXIMUM PAYMENT. The amount payable, under this benefit, for each covered person for all such vision care expenses incurred during any two calendar year period is $75.

Please refer to the separate fee schedule that is provided by the Plan Office.

B. SOME VISION CARE EXPENSES NOT REIMBURSABLE. No payment will be made under this benefit for expenses for:

1. non-prescription sunglasses; or

2. lenses or frames to replace lost or stolen lenses or frames.

GENERAL PROVISIONS & EXCLUSIONS

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Artificial organs: Any device intended to perform the function of a body organ.

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use., except tobacco cessation programs covered as a preventive service benefit under the Affordable Care Act.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental handicap, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally handicapped in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to: condoms,

contraceptive foams, jellies and ointments;

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Costs for services resulting from the commission of, or attempt to commit a felony by the covered person.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Court ordered services, including those required as a condition of parole or release.

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentist**s, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States.
- Immunizations related to travel or work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of **non-covered expenses**;
- Performance enhancing steroids;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable prescription drugs and medications;
- Any **prescription drug**s, injectable, or medications or supplies provided by the policyholder or through a third party vendor contract with the contract holder; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;

- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;

- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- creams, ointments and other supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing, including aids hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Home and mobility: Any addition or alternation to a home, workplace or other environment, or vehicle and any related equipment or device, including:

- Bathroom equipment such as bathtub seats, benches, rails, and lifts;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners,

water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alternations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alternations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Home uterine activity monitoring.
Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- ovulation induction and intrauterine insemination services if you are not fertile.

Maintenance Care
Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician**'s practice;
- Charges to have preferred access to a **physician**'s services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drug**s and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

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

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

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

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

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or

coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;

Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;

- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**;
- Services and supplies not obtained from an **IOE** including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Anti-reflective coatings;
- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet, including but not limited to:

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source.

COORDINATION WITH OTHER PROGRAMS

A. WITH "NO-FAULT". In the event a covered person under the health care portion of the plan has a claim which involves a motor vehicle occurrence covered by the "no-fault" insurance law of any State, there will be a "coordination of benefits" regarding reimbursement by this plan.

This coordination will apply in the event an expense is incurred for a covered event under this plan which also is covered under the "no-fault" provision. In such event, this plan will pay its benefits except that this plan will pay no greater part of a charge covered by this plan and "no-fault" than that which when added to the part payable under the "no-fault" coverage equals 100% of such charge.

Any claim savings resulting to this plan from this coordination with "no-fault" in a calendar year for a covered person will be used to increase the allowance otherwise payable under the plan for other covered expenses incurred, subsequently, in the same calendar year under the particular benefit involved. For the purposes of this paragraph, the hospital, surgical, diagnostic, doctor treatment, and major medical benefits will be considered one benefit.

B. WITH OTHER HEALTH CARE PLANS. Many times both husband and wife are covered by more than one group health care plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, your plan provides a coordination of benefits provision. The provision affects all your health care benefits.

In the event that a covered person under the health care portion of the plan is eligible under another plan providing medical benefits, these coordination of benefit rules apply. The coordination of benefit rules determine the portion of your expenses that will be paid by each plan. They will not reduce your total benefit in any way.

Under coordination of benefits, a set of rules is established to determine whether this plan or the other plan will be the "primary plan" and pay benefits first. If this plan is the primary plan, these rules determine the benefit payable regardless of the provisions of any other plan. If this plan is the secondary plan, it will pay benefits only after the primary plan has determined what it will pay.

If you are or your dependent is covered under another health care plan, the total amount received from all plans will never be more than 100% of "allowable expenses". "Allowable Expenses" are any necessary and reasonable expenses for medical services, treatment, or supplies, covered by one of the plans under which you or your dependents are covered. Benefits are reduced only to the extent necessary to prevent any person from making a profit on coverage.

For the purpose of these coordination of benefit rules, a "health care plan" is any group providing health care coverage on an insured or uninsured basis. This includes group Blue Cross, group Blue Shield, labor-management trustees' plans, union welfare plans, employer plans, and any coverage under governmental programs, student insurance plans, and no-fault auto insurance.

In general, if the other plan which may be liable for benefits does not contain a coordination of benefits provision, this plan will be the secondary plan. If the other plan does contain such a provision, this plan will be the primary plan if the person incurring the expense is covered by this plan as an employee. If the person incurring the expense is covered by this plan as a dependent, this plan will be the secondary plan if the other plan covers such person as a covered employee.

Benefits are determined for married participants' children by reference to the parents' birthdays. If your children are eligible for coverage under both this plan and a plan provided by your spouse's employer (and you and your spouse are not separated or divorced), this plan will be the primary plan if your birthday falls earlier in the year than your spouse's birthday. If you happen to have the same birthday, this plan will be the primary plan if it has covered you longer than your spouse's plan has covered your spouse. If neither of these rules apply, and if your spouse's plan determines the liability based on the gender of you and your spouse, the rules of your spouse's plan will govern.

For the children of divorced or separated parents, the plan covering the parent with custody is primary. If the parent with custody remarries, the order of payment is as follows:

1. natural parent with whom child resides;

2. step-parent with whom child resides; and

3. natural parent not having custody of the child.

If the divorce decree makes one parent liable for the expenses of the child's medical care, the plan covering that parent would be the primary plan regardless of these rules.

If, for some reason, the proper coordination of benefits cannot be determined under the rules described above, the provisions of the regulations issued by the New York State Department of Insurance will govern. This plan is a "complying plan" under those regulations.

It is your obligation to notify the plan if you, your spouse, or any of your dependents are covered by another health care plan. If you fail to do so, any amount by which the plan overpays benefits will be recovered from you, either directly, or through a reduction in future benefits.

Any claim savings resulting to this plan from this coordination with other health care plans in a calendar year for a covered person will be used to increase the allowances otherwise payable under the plan for other covered expenses incurred, subsequently, in the same calendar year under the particular benefit involved. For the purposes of this paragraph, the hospital, surgical, diagnostic, doctor treatment, and major medical benefits will be considered one benefit.

FOR RETIRED PERSONS ELIGIBLE FOR MEDICARE

The Aetna Medicare Plan (PPO) with Extended Service Area (ESA) provides your medical coverage, through a separate plan, if you choose to enroll. You must contact the Plan Office

to request an enrollment package before you reach Medicare eligibility.

If you wish to decline enrollment in the Aetna MA PPO, you should note that the Aetna MA PPO plan replaces the current IBEW Local 363 sponsored secondary coverage, so that opting out means you will no longer receive supplemental coverage from the Fund but will still retain your entitlement to Medicare Parts A and B.

SUMMARY OF DEATH AND DISABILITY BENEFITS

BENEFIT	DESCRIPTION
Death	Consecutive plan years: Up to 5 years $ 2,000. 5 to 9 years $ 5,000. 10 or more years $10,000. Retirees of the Local 631 with 500 hours in the 5 years prior to retirement will receive a $5,000 death benefit from the I.B.E.W. Local 363 Pension Fund in lieu of above
Disability Income	2/3 of pay to a maximum of $230. per week non-occupational; $100 per week occupational up to 26 weeks; maximum weekly benefit when added to statutory benefit is 50% of recent average gross wage. Your Disability Income benefit is subject to receiving a Federal or New York State disability determination.

DEATH BENEFIT

A. AMOUNT. The death benefit amount for a covered employee or pensioner will be determined by the number of consecutive "welfare plan years of coverage" the covered employee or pensioner has accumulated before retirement, as follows:

Up to 5 years	$ 2,000.
5 to 9 years	$ 5,000.
10 or more years	$10,000.

"Welfare Plan Year of Coverage" is a year in which you have completed the 1,200 hours required for coverage and were covered under the welfare plan. Remember, to accumulate welfare plan years, they must be in consecutive sequence.

Payment will be made to the beneficiary that the covered employee or pensioner names in the event of the covered employee's death from any cause while covered under this plan.

If your retirement date is after 12/31/95 and you were a member of Local 215 you will qualify for a death benefit if you qualify for retiree medical coverage under this plan. Your benefit will be based on your years of coverage in the Local 363 Welfare Plan.

B. BENEFICIARY. The beneficiary will be the person or persons designated in writing by the covered employee or pensioner and filed at the Plan Office.

The designated beneficiary may be changed at any time by the covered employee or pensioner by the completion, and submission to the Plan Office, of the proper form. A designation, or change, of beneficiary, received at the Plan Office after the employee's or pensioner's death will not be honored.

If there is no living designated beneficiary at the employee's or pensioner's death, the death benefit is payable to the estate of the deceased employee or pensioner.

DISABILITY BENEFIT

A. DESCRIPTION. Disability income benefits will be payable at the weekly rate stated in the summary of benefits, when the employee is wholly and continuously disabled, while the employee's coverage is in force, by an accidental bodily injury or sickness that prevents the employee from working at an occupation and which requires the regular care and attendance of a legally qualified physician or surgeon, pursuant to the New York State Disability Benefits Law.

Benefits begin with the first day of disability due to an accidental bodily injury or the eighth day due to a sickness, and will continue for a maximum of 26 weeks for any one period of disability, or in any one period of 52 consecutive weeks.

B. SUCCESSIVE PERIODS OF DISABILITY. Successive periods of disability due to the same or related causes, not separated by return to active employment, will be considered one period of disability.

PART C.

CLAIM PROCEDURE

GENERAL PROCEDURES

A claim for a reimbursement for a covered expense under a plan benefit must be submitted to the Plan Office in the format described by the Trustees.

43. If I submit my claim for reimbursement late, will I still be paid?

No. You should read the provisions regarding the submission of claims in Part C of this booklet.

44. If I am overpaid (or otherwise paid in error) for a claim, must I return the overpayment?

Yes. You are required to return the overpayment upon notification by the Plan Manager.

A claim for a death benefit must be made no later than the calendar year following the death, or it is not eligible for payment.

The deadline and format for a submission of a claim for a disability income benefit will be as set forth in the New York State Disability Benefits Law.

A claim for a health care benefit provided by the plan will not be payable as to any expense incurred more than 90 days prior to the date that the Plan Office receives written notice of the injury, sickness, or pregnancy that occasions such expense.

The claim procedures relating to any benefit provided through an insurance company will be as determined by such insurance company.

TRUSTEES' RIGHT TO EXAMINATION AND AUTOPSY

To the extent permitted by law, the Trustees will have the right and opportunity to examine any claimant (while living) when and so often as they may reasonably require and also, with respect to the accidental death and dismemberment benefit, the right and opportunity to make an autopsy where it is not forbidden by law.

The Trustees will have the right and opportunity to examine any claimant (while living) when and so often as it may reasonably require and, also, the right and opportunity to make an autopsy where it is not forbidden by law.

CLAIM DENIAL

In order to carry out their responsibility for interpreting the Plan and making determinations under it, the Trustees have exclusive authority and discretion to determine whether an individual is eligible for any benefits under a plan; to determine the amount of benefits, if any,

an individual is entitled to from a Plan; to interpret all of the Plan's provisions and to interpret all of the terms used in the Plan. All such determinations and interpretations made by the Trustees of their designee shall be final and binding upon any individual claiming benefits under a Plan; shall be given deference in all courts of law to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious or made in bad faith. All such determinations shall be based exclusively upon clearly defined and ascertainable criteria contained in the Plan.
If a claim is wholly or partially denied, the Plan Office will notify you within a reasonable period of time, not later than the following:

Type Of Claim	Time Limit For Claim Denial	Extension Permitted
Medical, Dental, Vision		
- Urgent Claims (as medically determined)	72 hours	None
- Pre-Service Claims	15 days	30 days
- Post-Service Claims	30 days	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None

If your claim lacks information required by the Plan Office to make a determination, you will be notified within a reasonable period of time. Extensions are permitted if the Plan Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time responding.

The Plan Office's notification of a claim denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, 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.

Filing Health Claims under the Plan
Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

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

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

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)
If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at

least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment
If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals
As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

A rule violation was minor and is not likely to influence a decision or harm you; and
It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

APPEAL

If your claim is denied, you or your duly authorized representative may appeal the denial to the Board of Trustees within the following timeframe:

Type Of Claim	Time Limit For Appealing Denial
Medical, Dental, Vision	180 days
Life Insurance	60 days

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and, in the case of a disability claim, a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

DETERMINATION OF APPEAL

The Board will make a determination of your appeal with a reasonable period of time, but not later than the following:

Type Of Claim	Time Limit For Claim Denial	Extension Permitted
Medical, Dental, Vision		
- Urgent Claims	72 hours	None
- Pre-Service Claims	15 days	30 days
- Post-Service Claims	Board meeting (if claim received 30 days prior)	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance	Board meeting (if claim received 30 days prior)	Next Board meeting

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible but not later than five days after the determination is made.

If the denial of a claim for medical, dental, or vision benefits was based in whole or in part on a medical judgment, the Board will consult with an independent professional who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual and who has appropriate training and experience in the field of medicine involved in the medical judgment. In addition, the determination on appeal will not afford deference to the initial claim denial. The Board will provide a written notification of the benefit determination on review. In the case of denial, the notification will set forth the following:

- The specific reason or reasons for the denial.
- Specific reference to Plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- An internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- if the adverse benefit determination is based on a medical necessity or experimental

treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- A statement of your right to sue under Section 502(a) of ERISA.

Health Claims – Voluntary Appeals
External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review
The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review
Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO
Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;

(iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately

must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review
The Plan must allow you to request an expedited External Review at the time you receive:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO
Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

INCOMPETENCE

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

COOPERATION

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

MAILING ADDRESS OF CLAIMANT

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

RECOVERY OF CERTAIN PAYMENTS

The Trustees have the right to recover any overpayment or mistake in payment made to claimant or to a third party on a claimant's behalf. Such recovery may be made by reducing other benefit payments made to the claimant or on the claimant's behalf, by commencing a legal action or by such other methods as the Trustees, in their discretion to be appropriate.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Important Notice of Your Right to Documentation of Health Coverage

You may need to provide other documentation for earlier periods of health care coverage.

To get a certificate, please contact the Plan Office.

The certificate must be provided to you promptly. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;

  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
- With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents
You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from the Fund Office. The form must be completed and returned to the Fund Office within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child
Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

To request special enrollment or obtain more information, contact: The Plan Office, Local Union No. 363 I.B.E.W. Welfare Plan, 67 Commerce Drive South, Harriman, NY 10926.

PART D.

NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protections. HIPAA requires that the Fund maintain the privacy of your protected health information (PHI). PHI is information the Fund has or receives that can identify an individual and that relates to any medical, prescription, dental, vision and/or Members Assistance Program benefits that you receive from the Fund, regardless of the form in which it is provided.

The Fund also is required by HIPAA to provide you with this description of the privacy policies and practices adopted by the Fund to safeguard PHI. The Fund must follow these policies and practices but, as permitted by law, the Fund reserves the right to amend or

modify them. Revisions to these policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material change to the Fund's privacy policies and practices within sixty (60) days of the change.

Does HIPAA permit the Fund to disclose my PHI to my employer? Under HIPAA, the Fund generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your PHI without your authorization to workers' compensation carriers, or others involved in the workers' compensation system, to the extent the disclosure is required by law as described below in further detail.

The privacy policy of the Fund is broken down into the following categories:

I. The Fund's uses and disclosures of PHI;

II. Your privacy rights with respect to your PHI;

III. The Fund's duties with respect to your PHI;

IV. Your right to file a complaint with the Fund and to the Secretary of the U.S. Department of Health and Human Services; and

V. The person or office to contact for further information about the Fund's privacy practices.

I. The Fund's Uses and Disclosures of PHI

Permitted PHI Uses and Disclosures that do not require your permission to use or release.

The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Fund's compliance with the privacy regulations. The Fund is also allowed to use and disclose your PHI without your permission under the following circumstances:

(1) For treatment, payment and health care operations.

How may the Fund use my PHI with respect to payment for my treatment, payment and health care operations? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payments for the services that you and your family are eligible to receive. The Fund may use your PHI for making payments to providers for services or treatment that you receive, for making arrangements for payments through one of the networks of providers through which the Fund provides benefits to you, and for coordinating payments to providers through other health Funds under the Fund's coordination of benefit rules.

a. *Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Fund may disclose to a

treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

b. *Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorization). For example, the Fund may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

c. *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business Funding and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes. For example, the Fund may use information to project future benefit costs or audit the accuracy of its claims processing functions

How may the Fund use my PHI with respect to health care operations? HIPAA allows the Fund to disclose an individual's PHI, without an authorization, to help the Fund assess the quality of the Fund's benefits as well as to monitor the Fund's administration and operations. These disclosures include, but are not limited to, disclosures to ensure that participants or their beneficiaries are eligible for benefits prior to making payments; disclosures to recover overpayments; disclosures to assess health Fund performance; disclosures to review the Fund's benefits and determine whether a reduction in costs is possible; disclosures to pursue case management and coordination of care; disclosures for actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the Fund; disclosures to resolve internal grievances; and disclosures as part of medical review, legal, and auditing functions. For example, the Fund may use PHI to determine the most cost-effective manner of providing vision benefits to its participants and beneficiaries. The Fund and its business associates (and any health insurers providing benefits to Fund participants) may also disclose the following to the Fund's Board of Trustees: (1) PHI for purposes related to Fund administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Fund; and (3) enrollment information (whether an individual is eligible for benefits under the Fund). The Trustees have amended the Fund to protect your PHI as required by federal law.

(2) Enrollment information provided to the Trustees.

(3) Summary health information provided to the Trustees for the purposes of treatment, payment, and health care operations.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be

disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform a minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) To a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Fund is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Fund's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

PHI Use and Disclosures that require you the opportunity to object prior to its use or release.

There are instances where uses and disclosures of your PHI require that you be given an opportunity to agree or disagree prior to the use or release. Unless you object, the Fund may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for

instance, an emergency situation, the Fund will disclose PHI (as the Fund determines) in your best interest. After the emergency, the Fund will give you the opportunity to object to future disclosures to family and friends.

Because I am always working, my spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information relating to payment of my claims to my spouse? The Fund will **not** provide claims payment or other PHI about you to your spouse **unless** you file a written authorization form with the Plan Office, as described later in this Notice.

May I call the Fund to get information about my children's health claims? The Fund will provide a minor child's parent, guardian (or person standing *in loco parentis* with respect to the child) with payment information about the child's claims.

The Fund will carefully consider your written request for information other than claims payment information, and will respond as permitted by its privacy policies and applicable state law.

If your child is **not** a minor, the Fund cannot provide you with the child's PHI, even if the child is still covered under the Fund as your dependent, unless the child files an authorization form with the Plan Office, as described later in this Notice.

PHI Use and Disclosures that you must give us authorization to use or release.

Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Fund will not use or disclose your psychiatric notes; the Fund will not use or disclose your PHI for marketing; and the Fund will not sell your PHI, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Fund receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

II. Rights of Individuals

Do I have rights under the federal privacy standards? Yes. Your rights to information under HIPAA include:

- *The right to request restrictions on the use and disclosure of your PHI.* You may request the Fund to restrict the uses and disclosures of your PHI. However, the Fund is not required to agree to your request (except that the Fund must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket). You or your personal representative will

be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official.

- *The right to receive confidential communications concerning your medical condition or treatment if you believe that disclosure of this information could endanger you.* For example, you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official. The Fund will attempt to honor reasonable requests for confidential communications.

- *The right to inspect and copy your PHI.* The Fund may charge a reasonable fee for copying, assembling and mailing your requested PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund; or other information used in whole or in part by or for the Fund to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Fund's Privacy Official. If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Fund's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services. The Fund may charge a reasonable, cost-based fee for copying records at your request.

- *The right to receive an electronic copy of your electronic medical records.* The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format.

- *The right to receive notice of a breach of your unsecured PHI.*

- *The right to amend or submit corrections to your PHI.* If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason that you wish to correct your records or if the records were not created by the Fund. You have the right to request the Fund to amend your PHI or a record about you in your designated record set for as long as the PHI

is maintained in the designated record set. The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or part, the Fund must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Fund's Privacy Official. You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

- *The right to receive an accounting of how and to whom you're PHI has been disclosed, if it was disclosed for reasons other than payment or health care operations.* At your request, the Fund will also provide you an accounting of disclosures by the Fund of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Fund's privacy practices. In addition, the Fund need not account for certain incidental disclosures. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

- *The right to file a complaint that your privacy rights have been violated, with the Fund and with the Secretary of U.S. Department of Health & Human Services*. You will **not** be penalized or otherwise retaliated against for filing a complaint.

- *The right to receive a printed copy of this Notice.*

To exercise these rights, you may file requests with the Plan Office, to the attention of the Fund's Privacy Officer, whose name, address, and telephone number appear below. The Plan Office will let you know if the Fund accepts or rejects your request (and why) in writing within the time set by law.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Fund retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

III.The Fund's Duties

The Fund is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Fund's legal duties and privacy practices. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Fund still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner. If the revised version of this Notice is posted on the Fund's website you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Fund's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Fund's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Fund or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Fund will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Fund's compliance with legal regulations.

De-Identified Information
This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information
The Fund may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Fund. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach
The Fund is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Fund will notify affected individuals of the breach.

IV. Your Right to File a Complaint With the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Fund. Such complaints should be made to the Fund's Privacy Official. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Fund will not retaliate against you for filing a complaint.

V. Whom to Contact at the Fund for More Information

The Fund has designated Pamela Brown as the Privacy Officer. If you wish to file an authorization, request information to which you have a right, or file a complaint with the Fund, or if you have any questions regarding this Notice, you should address them to:

Pamela Brown
HIPAA Privacy Officer
67 Commerce Drive South
Harriman, NY 10926

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Fund's Privacy Official.

Conclusion

PHI use and disclosure by the Fund is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Fund intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Please remember that the Fund can assess reasonable charges for copying, assembling and mailing to you any documents that you request.

PART E.

YOUR RIGHTS UNDER ERISA

As a participant in the health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

A. Examine, without charge, at the Plan Office, all plan documents, including insurance contracts, 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.

B. Obtain, upon written request to the Trustees, copies of documents governing the operations 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 Trustees may make a reasonable charge for the copies.

C. Receive a summary of the plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trustees to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trustees. If you have a claim for benefits which is denied, or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations 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 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.

If you have any questions about this statement or about your rights under ERISA, you may contact the nearest Regional Office of the Employee Benefits Security Administration, U.S. Department of Labor. This office is located at 33 Whitehall Street, Suite 1200, New York, NY 10010; the phone number is (212) 607-8600; the fax number is (212) 607-8681.

You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W.,

Washington, DC 20210.

PART F.

TECHNICAL DETAILS

(As required by the Employee Retirement Income Security Act of 1974)

1. PLAN NAME: Local Union No. 363 I.B.E.W. Welfare Plan.

2. EDITION DATE: This Summary Plan Description is produced as of May 1, 2017.

3. PLAN SPONSOR: Board of Trustees of Local Union No. 363 I.B.E.W. Welfare Plan.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 13-6132502.

5. PLAN NUMBER: 501 (assigned by federal government).

6. TYPE OF PLAN: Welfare plan providing death benefits and health care cost reimbursement benefits.

7. PLAN YEAR ENDS: December 31.

8. PLAN ADMINISTRATOR: Board of Trustees of I.B.E.W. Local Union 363 Welfare Plan, 67 Commerce Drive South, Harriman, NY 10926. Phone #: (845) 783-6619.

9. AGENT FOR THE SERVICE OF LEGAL PROCESS: Archer, Byington, Glennon & Levine, LLP, One Huntington Quadrangle, Suite 4C10, Melville, NY 11747-9064. Phone #: (631) 249-6565.

In addition to the person designated as agent for service of legal process, service of legal process may also be made upon any plan Trustee.

10. TYPE OF PLAN ADMINISTRATION: Direct employees of the Board of Trustees.

11. TYPE OF FUNDING: Self-administered.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Local Union No. 363 I.B.E.W. Welfare Plan and certain other welfare plans with whom this welfare plan has reciprocal agreements from time to time. You are also required to maintain contributions to the Plan on a monthly basis.

13. COLLECTIVE BARGAINING AGREEMENT: This plan is maintained in accordance with a collective bargaining agreement. A copy of this agreement may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Plan Office.

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

15. PLAN BENEFITS PROVIDED BY: The Local Union No. 363 I.B.E.W. Welfare Plan.

16. ELIGIBILITY REQUIREMENTS, BENEFITS AND TERMINATION PROVISIONS OF THE PLAN: See Parts A. & B. of this booklet.

17. HOW TO FILE A CLAIM: Application for all benefits must be made in writing on forms that should be obtained from the Plan Manager at the Plan Office. You may secure such forms by writing, telephoning, or visiting (during the hours of 9:00 A.M. to 5:00 P.M., on regular business days) the Plan Office. The address is:

67 Commerce Drive South
Harriman, NY 10926
Phone #: (845) 783-6619

18. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Plan Office and it is denied, in whole or in part, you will be notified.

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees, within 60 days of the denial, at the Plan Office, asking that a review of the denial be made. You, or your representative, may review the pertinent records and documents. You may attend the review hearing.

After the review, you will be notified of the results of the review.

More specific information regarding this procedure may be obtained from the Plan Manager.

19. NO INSURANCE UNDER THE PBGC: Since this plan is not a defined-benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

20. TRUSTEES: The Plan Sponsor and Plan Manager is the Board of Trustees of Local Union No. 363 I.B.E.W. Welfare Plan. The following are the individual Trustees that make up the Board as of May 1, 2017:

John Dickson
67 Commerce Drive South
Harriman, NY 10926

Joseph DeLeonardis
DeLeonardis Electric, Inc.
P.O. Box 108
Garnerville, NY 10923

Sam Fratto, III
67 Commerce Drive South
Harriman, NY 10926

Robert Kaehler
Perreca Electric
520 Broadway
Newburgh, NY 12550

Gil Heim
67 Commerce Drive South

James Johannemann
All Bright Electric

Harriman, NY 10926

John A. Maraia.
67 Commerce Drive South
Harriman, NY 10926

James Matich
67 Commerce Drive South
Harriman, NY 10926

Steve Neugebauer
67 Commerce Drive South
Harriman, NY 10926

100 Snake Hill Road
West Nyack, NY 10994

Richard Parker
Richard Parker Electric, Inc.
P.O. Box 198
Sloatsburg, NY 10974

Jeffrey Seidel
J.L.S. Contracting, Inc.
57A New Valley Road
New City, NY 10956

Robert Metz
Napp Electric
249 Cottage St.
Middletown, NY 10940