NATIONAL HEALTH & WELFARE FUND PLAN C

Summary Plan Description
# Health & Welfare Fund Board of Trustees

<table>
<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew D. Loeb (Co-Chair)</td>
<td>Christopher Brockmeyer (Co-Chair)</td>
</tr>
<tr>
<td>IATSE, International President</td>
<td>Director of Employee Benefit Funds</td>
</tr>
<tr>
<td>1430 Broadway, 20th Floor</td>
<td>The Broadway League</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>226 West 47th Street, 6th Floor</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10036</td>
</tr>
<tr>
<td>Brian J. Lawlor</td>
<td>Howard S. Welinsky</td>
</tr>
<tr>
<td>IATSE, International Representative</td>
<td>Senior Vice-President, Domestic Sales</td>
</tr>
<tr>
<td>1430 Broadway, 20th Floor</td>
<td>Warner Bros.</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>3903 West Olive, Suite 2191</td>
</tr>
<tr>
<td></td>
<td>Burbank, CA 91505</td>
</tr>
<tr>
<td>James B. Wood</td>
<td>Carol A. Lombardini, Esq.</td>
</tr>
<tr>
<td>IATSE, General Secretary-Treasurer</td>
<td>President</td>
</tr>
<tr>
<td>1430 Broadway, 20th Floor</td>
<td>Alliance of Motion Picture &amp; Television Producers (AMPTP)</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>15301 Ventura Blvd, Building E</td>
</tr>
<tr>
<td></td>
<td>Sherman Oaks, CA 91403-5885</td>
</tr>
<tr>
<td>Daniel E. DiTolla</td>
<td>Dean Ferris</td>
</tr>
<tr>
<td>IATSE, International Vice President</td>
<td>c/o Fund Office</td>
</tr>
<tr>
<td>1430 Broadway, 20th Floor</td>
<td>417 Fifth Avenue</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>New York, NY 10016</td>
</tr>
<tr>
<td>Patricia A. White</td>
<td>Paul Libin</td>
</tr>
<tr>
<td>IATSE, Representative</td>
<td>Vice President and Producing Director</td>
</tr>
<tr>
<td>1430 Broadway, 20th Floor</td>
<td>Jujam cyn Theaters</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>246 West 44th Street, Suite 801</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10036</td>
</tr>
<tr>
<td>Michael F. Miller, Jr.</td>
<td>Sean T. Quinn</td>
</tr>
<tr>
<td>IATSE, International Vice President</td>
<td>Vice President, Labor Relations</td>
</tr>
<tr>
<td>Director, Motion Picture and Television Production</td>
<td>ABC, Inc.</td>
</tr>
<tr>
<td>10045 Riverside Drive</td>
<td>77 West 66th Street</td>
</tr>
<tr>
<td>Toluca Lake, CA 91602</td>
<td>New York, NY 10023</td>
</tr>
<tr>
<td></td>
<td>Seth Popper</td>
</tr>
<tr>
<td>William E. Gearn, Jr.</td>
<td>Director of Labor Relations</td>
</tr>
<tr>
<td>IATSE, Representative</td>
<td>Broadway League</td>
</tr>
<tr>
<td>1430 Broadway, 20th floor</td>
<td>729 Seventh Avenue, 5th Floor</td>
</tr>
<tr>
<td>New York, NY 10018</td>
<td>New York, NY 10019</td>
</tr>
</tbody>
</table>

**EXECUTIVE DIRECTOR**
Anne J. Zeisler

**FUND COUNSEL**
Spivak Lipton LLP
Proskauer Rose LLP

**FUND CONSULTANTS**
The Segal Company
From the Board of Trustees

Dear Participant:

We are pleased to present this revised booklet about the IATSE National Health & Welfare Fund Plan C, which describes each of the benefits available to participants, including:

- hospital and medical coverage for you and your covered dependents through Empire BlueCross BlueShield
- prescription drug benefits for you and your covered dependents through CVS Caremark
- in Puerto Rico, the Triple-S preferred provider organization (PPO) as an alternative to Empire and CVS Caremark
- dental benefits for you and your covered dependents through Delta Dental or, if you live in New York, Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS)
- vision services for you and your covered dependents through Davis Vision
- a Medical Reimbursement Program for certain unreimbursed medical expenses incurred by you and your covered dependents
- life insurance for you through the United States Life Insurance Company in the City of New York (“AIG/US Life”)
- a retiree health benefit plan for you and your spouse if you meet the eligibility requirements.

This Summary Plan Description (SPD) booklet provides a description of Plan C provisions in effect as of November 1, 2012. To help you understand the defined terms used in this booklet, they are italicized throughout, featured in the “Terms You Should Know” at the start of each section and included in the glossary that starts on page 148.

After reading this booklet, if you have questions about the Plan or would like more information, contact the Fund Office. A staff member will be pleased to assist you with any questions or concerns you may have.

The Board of Trustees
Introduction

The IATSE National Health & Welfare Fund (referred to in this booklet as “the Fund”) was set up to provide health care benefits to eligible participants. It was established as the result of various collective bargaining agreements between employers and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada and its Affiliated Locals (the “Union”). These collective bargaining agreements are contracts between employers and the Union that, among other things, require employers to contribute to the Health & Welfare Fund on behalf of employees who are covered by the IATSE National Health & Welfare Plan C (referred to in this booklet as “the Plan” or “Plan C”). This booklet describes the Plan provisions as of November 1, 2012.

We’ve tried to explain things in everyday language, but you will come across some words and phrases that have specific meanings within the context of the Plan. To help you understand them, they are featured in the “Terms You Should Know” box at the start of each section and included in the glossary that starts on page 148. Many of them are also italicized throughout the booklet for easy recognition.

The Plan is administered by a Board of Trustees consisting of representatives appointed by the Union and the contributing employers. The Board of Trustees acts on behalf of you and your fellow Plan participants to manage all aspects of the Fund’s operations.

Although this booklet provides essential information about your benefits, this information is intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits is contained in related documents, such as insurance contracts and/or certificates of coverage. If there is ever a conflict between these summaries and the official Plan documents, the official documents will govern.

In addition, future changes to the benefits and eligibility rules described in this book will be communicated through newsletters and/or other notices from the Fund Office. Be sure to read all mail from the Fund Office carefully, and keep all announcements of Plan C changes with this booklet for easy reference. You can also generally find updates on the Fund’s Web site by logging on to www.iatsenbf.org.

Contacting the Fund Office
IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
1-212-580-9092 in New York
1-800-456-FUND (3863) outside New York
Web site: www.iatsenbf.org
Email: participantstservicescenter@iatsenbf.org
Your Role in Managing Your Benefits

It is important that you play an active role in managing your benefits to ensure that health care coverage for yourself and your eligible dependents begins when you become eligible and continues uninterrupted for as long as you remain eligible. For most participants, ongoing participation in Plan C is not automatic.

- You must review the level of employer contributions received by the Fund on your behalf at least quarterly and, if a self-payment is required, send it in on time. If you fail to take these actions, or if you miss a payment deadline, you risk a lapse or downgrade in coverage.

- If you have other coverage and want to use employer contributions for reimbursement of your medical premiums or other qualifying expenses, you must provide proof of your other coverage each year during Annual Enrollment. Otherwise, you will be automatically enrolled in coverage that you may not want or need.

The Fund provides resources to help you track your account and take actions on time. You will receive a quarterly statement with clearly marked deadlines. You can also get the information you need online or through an interactive voice response (IVR) telephone system. Regardless of how you choose to access the information, it’s your responsibility to do so—and to take the required actions.

It is also essential that you keep Plan records (for example, your contact information, marital status and dependents) up to date. If the Fund has incorrect information on file, your coverage may not begin when you would be otherwise eligible or, if you are already participating, it may lapse or be downgraded. Also, be sure to report changes—especially beneficiary updates—to any other Funds in which you participate.

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

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>9</td>
</tr>
<tr>
<td>Who Is Eligible</td>
<td>10</td>
</tr>
<tr>
<td>Qualified Medical Child Support Orders (QMCSOs)</td>
<td>11</td>
</tr>
<tr>
<td>Domestic Partnerships</td>
<td>12</td>
</tr>
<tr>
<td><strong>Your CAPP Account</strong></td>
<td>14</td>
</tr>
<tr>
<td>Keeping Track of Your CAPP Account Balance</td>
<td>15</td>
</tr>
<tr>
<td>Combining and Uncombining CAPP Accounts</td>
<td>15</td>
</tr>
<tr>
<td><strong>Initial Participation</strong></td>
<td>17</td>
</tr>
<tr>
<td>Optional Enrollment</td>
<td>18</td>
</tr>
<tr>
<td>Automatic Enrollment</td>
<td>20</td>
</tr>
<tr>
<td>Enrollment Summary</td>
<td>21</td>
</tr>
<tr>
<td>Choosing Plan C-MRP (Medical Reimbursement Program) as a Standalone Option</td>
<td>21</td>
</tr>
<tr>
<td>Self-Payments</td>
<td>23</td>
</tr>
<tr>
<td><strong>Plan C-MRP (Medical Reimbursement Program)</strong></td>
<td>24</td>
</tr>
<tr>
<td>Enrolling in Plan C-MRP as a Standalone Option</td>
<td>24</td>
</tr>
<tr>
<td>Participating in Plan C-MRP as a Supplement to Plan C-1, C-2 or C-3</td>
<td>27</td>
</tr>
<tr>
<td>Administrative Charge</td>
<td>27</td>
</tr>
<tr>
<td>Qualifying Expenses</td>
<td>28</td>
</tr>
<tr>
<td>Claiming Reimbursement</td>
<td>31</td>
</tr>
<tr>
<td><strong>Continuing Participation</strong></td>
<td>32</td>
</tr>
<tr>
<td>Automatic Downgrades</td>
<td>34</td>
</tr>
<tr>
<td>Participation Termination (Loss of Eligibility)</td>
<td>35</td>
</tr>
<tr>
<td>Forfeited CAPP Accounts</td>
<td>35</td>
</tr>
<tr>
<td>Keep Personal Information Up to Date</td>
<td>36</td>
</tr>
<tr>
<td><strong>Changing Your Coverage</strong></td>
<td>37</td>
</tr>
<tr>
<td>Change in Family Status and Special Enrollment Situations</td>
<td>37</td>
</tr>
<tr>
<td><strong>When Coverage Ends</strong></td>
<td>39</td>
</tr>
<tr>
<td>If a Participant Dies</td>
<td>42</td>
</tr>
<tr>
<td>Continuation of Health Care Coverage under COBRA</td>
<td>43</td>
</tr>
<tr>
<td>Certificate of Creditable Coverage</td>
<td>46</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>47</td>
</tr>
</tbody>
</table>
## Hospital and Health Benefits

- Managing Your Health Care Online 51
- Your Identification Card 52
- Plan Basics 52
- How to Find an In-Network Provider 55
- How Much You Will Pay—Maximum Allowed Amount 57
- What Is Covered 60
- Doctor’s Services 61
- Emergency Care 65
- Maternity Care 67
- Infertility Treatment 69
- Hospital Services 71
- Durable Medical Equipment and Supplies 75
- Skilled Nursing and Hospice Care 77
- Home Health Care 78
- Physical, Occupational, Speech and Vision Therapy 79
- Behavioral Health Care 80
- Other Services Not Covered 82
- Health Management 85
- Precertification and Medical Management 86
- Case Management 90
- 360° Health 90

## Prescription Drug Benefit

- Retail Pharmacy 91
- Mail Service Pharmacy 92
- Refilling Prescriptions 94
- What Is Covered 94
- What Is Not Covered 94

## Vision Care Benefit

- What Is Covered 96
- Receiving Services from an In-Network Provider 98
- If You Use an Out-of-Network Provider 98
- What Is Not Covered 99

## Dental Benefit

- Eligible Expenses 101
- How Much You Will Pay 101
- What Is Covered 102
- Predetermination of Benefits 102
- What Is Not Covered 103
- Filing a Claim for Dental Benefits 104
- Schedule of Dental Benefits 105

## Benefits for Physical Exams and Hearing Aids

## Life Insurance Benefit

- Naming a Beneficiary 113
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Health Benefit Plan</td>
<td>115</td>
</tr>
<tr>
<td>Eligibility</td>
<td>115</td>
</tr>
<tr>
<td>What the Benefit Is</td>
<td>116</td>
</tr>
<tr>
<td>Spouse Coverage</td>
<td>116</td>
</tr>
<tr>
<td>Medicare Benefits</td>
<td>116</td>
</tr>
<tr>
<td>How to Claim Benefits</td>
<td>117</td>
</tr>
<tr>
<td>Continuation of Benefits</td>
<td>117</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>118</td>
</tr>
<tr>
<td>Other Group Medical Plans</td>
<td>118</td>
</tr>
<tr>
<td>Which Plan Pays First</td>
<td>118</td>
</tr>
<tr>
<td>Claims and Appeals Procedures</td>
<td>121</td>
</tr>
<tr>
<td>Definition of a Claim</td>
<td>122</td>
</tr>
<tr>
<td>Where to File Claims</td>
<td>122</td>
</tr>
<tr>
<td>When Claims Must Be Filed</td>
<td>124</td>
</tr>
<tr>
<td>Authorized Representatives</td>
<td>125</td>
</tr>
<tr>
<td>Claims Procedures</td>
<td>125</td>
</tr>
<tr>
<td>Preservice and Urgent Care Claims</td>
<td>125</td>
</tr>
<tr>
<td>Concurrent Claims</td>
<td>127</td>
</tr>
<tr>
<td>Postservice Claims</td>
<td>127</td>
</tr>
<tr>
<td>Life Insurance Claims</td>
<td>128</td>
</tr>
<tr>
<td>Eligibility Claims</td>
<td>128</td>
</tr>
<tr>
<td>Notice of Decision</td>
<td>129</td>
</tr>
<tr>
<td>Request for Review of Denied Claim</td>
<td>129</td>
</tr>
<tr>
<td>Review Process</td>
<td>130</td>
</tr>
<tr>
<td>Timing of Notice of Decision on Appeal</td>
<td>131</td>
</tr>
<tr>
<td>Notice of Decision on Review</td>
<td>132</td>
</tr>
<tr>
<td>External Review</td>
<td>133</td>
</tr>
<tr>
<td>Limitation on When a Lawsuit May Be Started</td>
<td>134</td>
</tr>
<tr>
<td>Subrogation and Reimbursement</td>
<td>135</td>
</tr>
<tr>
<td>The Health Insurance Portability and Accountability Act of 1996 (HIPAA)</td>
<td>138</td>
</tr>
<tr>
<td>Other Information You Should Know</td>
<td>141</td>
</tr>
<tr>
<td>Board of Trustees</td>
<td>141</td>
</tr>
<tr>
<td>Collective Bargaining Agreement and Contributing Employers</td>
<td>142</td>
</tr>
<tr>
<td>Recovery of Overpayments</td>
<td>142</td>
</tr>
<tr>
<td>Assignment of Plan Benefits</td>
<td>142</td>
</tr>
<tr>
<td>Plan Facts</td>
<td>143</td>
</tr>
<tr>
<td>Your Rights under the Employee Retirement Income Security Act of 1974 (ERISA)</td>
<td>144</td>
</tr>
<tr>
<td>Administration and Contact Information</td>
<td>146</td>
</tr>
<tr>
<td>Glossary</td>
<td>148</td>
</tr>
</tbody>
</table>
Plan Highlights

HOSPITAL AND HEALTH BENEFITS

<table>
<thead>
<tr>
<th>EMPIRE BLUECROSS BLUESHIELD PLAN C-1</th>
<th>EMPIRE BLUECROSS BLUESHIELD PLAN C-2</th>
<th>EMPIRE BLUECROSS BLUESHIELD PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans C-1 and C-2 both offer in-network and out-of-network benefits. All reimbursements of eligible out-of-network expenses are paid as a percentage of Empire BlueCross BlueShield’s maximum allowed amount, which is the maximum Empire will pay for any service or supply. If an out-of-network provider charges more than the maximum allowed amount, you will be responsible for the excess, in addition to your normal coinsurance. In addition, applicable services or service frequencies are applied to both in-network and out-of-network care combined.</td>
<td>Plan C-3 requires you to use an in-network provider. The doctor’s office copays apply to exams and evaluations only. Other services you receive may be subject to the applicable deductible and coinsurance. If you go to an out-of-network provider, no benefits will be paid.</td>
<td>See pages 48 to 90 for a more detailed description of benefits and other provisions, including the precertification requirement that applies to some services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEATURES</th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALENDAR YEAR DEDUCTIBLE</td>
<td>$0</td>
<td>$200/Individual $500/Family</td>
<td>$0</td>
</tr>
<tr>
<td>COINSURANCE</td>
<td>N/A</td>
<td>You pay 25% of maximum allowed amount and Plan pays 75% of maximum allowed amount (50% for behavioral health care services)</td>
<td>For certain services indicated below, you pay 20% of maximum allowed amount and Plan pays 80%</td>
</tr>
<tr>
<td>ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM</td>
<td>N/A</td>
<td>$1,500/Individual $3,750/Family</td>
<td>$1,000/Individual $2,500/Family</td>
</tr>
<tr>
<td>LIFETIME MAXIMUM</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>CLAIM FORMS TO FILE</td>
<td>None</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>ANNUAL MAXIMUM BENEFIT</td>
<td>N/A</td>
<td>$1 million in 2011; $1.25 million in 2012; $2 million in 2013; N/A after 2013</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.
For more details for a benefit shown below, go to the page number included in the first column. A benefit listed with a telephone symbol in the first column indicates that precertification is required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

**Special note on coverage for preventive care:** Preventive care (including physical exams, screenings, tests and counseling) that meets certain government standards under the Affordable Care Act is covered in full if provided in-network. Office visits will be covered in full only if the primary purpose is preventive care that meets these standards. For more information as to whether a particular service will be covered in full, please contact Empire BlueCross at 1-800-553-9603.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR’S OFFICE VISITS, INCLUDING SPECIALISTS (PAGE 61)</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>$30 per visit (not subject to deductible)</td>
</tr>
<tr>
<td>CHIROPRACTIC VISITS (PAGE 63)</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>$30 for exam and evaluation, other services subject to deductible and 20% coinsurance</td>
</tr>
<tr>
<td>ANNUAL PHYSICAL EXAM</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>$30 for exam and evaluation, other services subject to deductible and 20% coinsurance</td>
</tr>
<tr>
<td>ALLERGY CARE</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>WELL WOMAN CARE (PAGE 61)</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>Deductible &amp; 20% coinsurance</td>
</tr>
<tr>
<td>WELL CHILD CARE (PAGE 62)</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
<td>Deductible &amp; 20% coinsurance</td>
</tr>
</tbody>
</table>

* In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.

- Precertification required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

& Precertification required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays &amp; other imaging; MRIs/MRAs</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>Deductible &amp; 40% coinsurance</td>
</tr>
<tr>
<td>All lab tests</td>
<td></td>
<td>20% coinsurance</td>
<td>Deductible &amp; 20% coinsurance</td>
</tr>
<tr>
<td><strong>Emergency Room (Page 66)</strong></td>
<td>$35 per visit (waived if admitted within 24 hours)</td>
<td>$50 per visit (waived if admitted within 24 hours)</td>
<td>$50 per visit (waived if admitted within 24 hours)</td>
</tr>
<tr>
<td>Ambulance (Page 66)</td>
<td>$0</td>
<td>$0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge.</td>
<td>$0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge.</td>
</tr>
<tr>
<td>Maternity Care (Page 67)</td>
<td>$20 copay for initial visit</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>$25 for initial exam and evaluation, other services subject to 20% coinsurance</td>
</tr>
<tr>
<td>Lab tests, sonograms &amp; other diagnostic procedures</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Obstetrical care in hospital (in hospital)</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Routine newborn nursery care (in hospital)</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Obstetrical care (in birthing center)</td>
<td>$0</td>
<td>Not covered</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

*Precertification required. (Certification required within 48 hours of an emergency hospital admission.) If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

*In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.
<table>
<thead>
<tr>
<th></th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFITS</strong></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK*</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td><strong>HOSPITAL SERVICES</strong></td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>CHEMOTHERAPY, X-RAY, RADIUM &amp; RADIONUCLIDE THERAPY</strong></td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td>$0</td>
<td>Not covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>MEDICAL SUPPLIES</strong></td>
<td>$0</td>
<td>Difference between the maximum allowed amount and the total charge (deductible &amp; coinsurance do not apply)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>NUTRITIONAL SUPPLEMENTS</strong></td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td>$0</td>
<td>Not covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>HOSPICE CARE</strong></td>
<td>$0</td>
<td>Not covered</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

*In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.*

Semi-private room & board; general, special & critical nursing care; intensive care; services of physicians & surgeons; anesthesia, oxygen, blood work, diagnostic x-rays & lab tests; chemotherapy & radiation therapy; drugs & dressings; presurgical testing; surgery (inpatient & outpatient)

The hospital services benefit does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Outpatient hospital surgery and inpatient admissions need to be precertified.

* **Precertification** required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>HOME HEALTH CARE (PAGE 79)</td>
<td>$0</td>
<td>25% coinsurance, no deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Up to 200 visits per calendar year (a visit equals 4 hours of care) (treatment maximums are combined for in-network and out-of-network services)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td>HOME INFUSION THERAPY</td>
<td>$0</td>
<td>Not covered</td>
<td>$0</td>
</tr>
<tr>
<td>PHYSICAL THERAPY &amp; REHABILITATION (PAGE 79)</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Up to 30 days of in-patient service per calendar year (treatment maximums are combined for in-network and out-of-network care)</td>
<td>$20 per visit</td>
<td>Not covered</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Up to 30 visits combined in home, office or outpatient facility per calendar year</td>
<td>20% coinsurance</td>
<td>$25 per visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>OCCUPATIONAL, SPEECH OR VISION THERAPY (PAGE 79)</td>
<td>$20 per visit</td>
<td>Not covered</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Up to 30 visits combined in home, office or outpatient facility per calendar year</td>
<td>25% coinsurance</td>
<td>$25 per visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>CARDIAC REHABILITATION</td>
<td>$20 per outpatient visit</td>
<td>Deductible &amp; 25% coinsurance</td>
<td>$25 per outpatient visit</td>
</tr>
</tbody>
</table>

*Precertification required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.*

*In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.*
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK*</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>MENTAL HEALTH CARE (PAGE 81)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT (c)</td>
<td>Up to 40 visits per calendar year (treatment maximums are combined for in-network and out-of-network care)</td>
<td>$25 per visit</td>
<td>Deductible &amp; 50% coinsurance</td>
</tr>
<tr>
<td>INPATIENT (c)</td>
<td>Up to 30 days per calendar year</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Up to 30 visits from mental health care professionals per calendar year</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>ALCOHOL OR SUBSTANCE ABUSE TREATMENT (PAGE 82)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT (c)</td>
<td>Up to 60 visits per calendar year, including up to 20 visits for family counseling (treatment maximums are combined for in-network and out-of-network care)</td>
<td>$0</td>
<td>Deductible &amp; 25% coinsurance</td>
</tr>
<tr>
<td>INPATIENT (c)</td>
<td>Up to 7 days of detoxification per calendar year</td>
<td>$0</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

(c) Precertification required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

* In addition to coinsurance, you must pay 100% of any amount your provider charges in excess of the maximum allowed amount, and the excess amount does not count toward the coinsurance maximum.
### OTHER WELFARE FUND BENEFITS

<table>
<thead>
<tr>
<th>PLAN C-1 AND PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
</table>
| **PRESCRIPTION DRUGS (PAGE 91)** | **AT AN IN-NETWORK PHARMACY:** You can receive a 30-day supply or refill of a medication through a Caremark in-network pharmacy. The copays are:  
**PLAN C-1:** $5 for a generic drug, 20% ($20 minimum/$35 maximum) for a brand-name drug with no generic equivalent and 40% ($30 minimum/$45 maximum) for a brand-name drug with a generic equivalent.  
**PLAN C-2:** $5 for a generic drug, 20% ($35 minimum/$50 maximum) for a brand-name drug with no generic equivalent and 40% ($45 minimum/$60 maximum) for a brand-name drug with a generic equivalent. | **AT AN IN-NETWORK PHARMACY:** You can receive a 30-day supply or refill of a medication through a Caremark network pharmacy. The copays are $5 for a generic drug, 20% ($35 minimum/$50 maximum) for a brand-name drug with no generic equivalent and 40% ($45 minimum/$60 maximum) for a brand-name drug with a generic equivalent. |
| **MAIL-ORDER PHARMACY:** You can receive a 90-day supply via mail order or a local CVS pharmacy. The copays are:  
**PLAN C-1:** $12.50 for a generic drug, 20% ($50 minimum/$87.50 maximum) for a brand-name drug with no generic equivalent and 40% ($75 minimum/$112.50 maximum) for a brand-name drug with a generic equivalent.  
**PLAN C-2:** $12.50 for a generic drug, 20% ($87.50 minimum/$125 maximum) for a brand-name drug with no generic equivalent and 40% ($112.50 minimum/$150 maximum) for a brand-name drug with a generic equivalent. | **AT AN OUT-OF-NETWORK PHARMACY:** You must pay the full charge and then file a claim for reimbursement with Caremark for the difference between the pharmacy’s charge and the applicable copay.  
Certain limitations and exclusions may apply to some medications. |
| **VISION CARE (PAGE 96)** | **No coverage** |
| Through Davis Vision, Plans C-1 and C-2 offer one eye exam and one pair of glasses or contact lenses from an approved group of products every 24 months. For covered children, an exam and lenses are provided every 12 months, while frames are available only every 24 months. There may be an additional charge for contact lenses or frames that are not in the approved group.  
For out-of-network vision services, reimbursement of up to $100 is available every 24 months (every 12 months for exams and lenses for children). In addition, the Plan will cover the cost of annual exams for children through age 18 up to the applicable in-network reimbursement amount. | |

Any prescription considered preventive care under the Affordable Care Act will be covered in full in network if required by that Act. For more information as to whether a particular service will be covered in full, please contact CVS Caremark at 1-800-896-1997.
### OTHER WELFARE FUND BENEFITS

<table>
<thead>
<tr>
<th>PLAN C-1 AND PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL EXAM &amp; HEARING AID BENEFIT (PAGE 112)</strong></td>
<td>PHYSICAL EXAM: If you do not go to a BlueCross provider for a physical exam, the Plan pays up to $300 per calendar year for a physical examination.</td>
</tr>
<tr>
<td></td>
<td>HEARING AID: The Plan pays up to $1,500 in a 36-month period for a hearing aid, batteries and/or repairs</td>
</tr>
<tr>
<td><strong>PUERTO RICO</strong></td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>The Triple S PPO (or other equivalent plan) is available only in Puerto Rico. If you elect this coverage, you will not be eligible for the hospital, medical and prescription drug benefits described above, but you will be entitled to the vision care, dental and life insurance benefits. Contact the plan for more information.</td>
</tr>
<tr>
<td><strong>DENTAL CARE (PAGE 100)</strong></td>
<td>Covers only basic preventive care in accordance with schedule of dental benefits</td>
</tr>
<tr>
<td></td>
<td>Oral exams and cleanings, up to two of each per calendar year</td>
</tr>
<tr>
<td></td>
<td>X-rays, once per calendar year</td>
</tr>
<tr>
<td></td>
<td>In-network dentists have agreed to charge a negotiated fee set by Delta Dental.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network dentists are paid the same amount under the fee schedule as in-network dentists, but an out-of-network dentist may charge you an additional amount.</td>
</tr>
<tr>
<td></td>
<td>Orthodontia not covered.</td>
</tr>
<tr>
<td><strong>PLAN C-MRP (MEDICAL REIMBURSEMENT PROGRAM) (PAGE 24)</strong></td>
<td>You may use certain excess funds in your CAPP account as reimbursement for:</td>
</tr>
<tr>
<td></td>
<td>Expenses that aren’t paid in full under your Fund medical coverage</td>
</tr>
<tr>
<td></td>
<td>Premiums you pay for medical coverage other than that provided by the Fund (if you do not have the Fund’s medical coverage).</td>
</tr>
<tr>
<td><strong>LIFE INSURANCE (PAGE 113)</strong></td>
<td>Pays a benefit of $20,000 if you die. (Life insurance is not available for covered dependents.)</td>
</tr>
<tr>
<td></td>
<td>No coverage</td>
</tr>
</tbody>
</table>
Eligibility

Terms You Should Know...

• **Affiliated Local** is a local union chartered by or affiliated with the Union.

• **Beneficiary** means the person you name to receive any life insurance benefits provided by the Plan if you die.

• **Annual Enrollment**, which runs from mid-November through December 15 each year, is the only time of year you can change your level of coverage (unless you experience a qualifying event such as marriage or the birth of a child). If you make a change during Annual Enrollment, it will become effective the following January 1.

• **Collective bargaining agreement** means a negotiated agreement between an employer and the Union or an Affiliated Local requiring contributions to the IATSE National Health & Welfare Fund. It determines the amount of contributions employers are required to make to the Fund for work in covered employment.

• **Contributing employer** is an employer that has signed a collective bargaining agreement with the Union or an Affiliated Local. The Fund, the Union and Affiliated Locals may be contributing employers if they contribute to the IATSE National Health & Welfare Fund pursuant to a written agreement.

• **Covered employment** means work covered by a collective bargaining agreement or another agreement that requires your employer to make contributions to the IATSE National Health & Welfare Fund Plan C on your behalf.

• **Dependent children** are natural children, stepchildren, children required to be recognized under a QMCSO and adopted children (including children to be adopted during a waiting period before finalization of the adoption) who are dependent on you for financial support.

• **Domestic partners** are two adults of the same sex who meet the Plan’s definition of domestic partners on page 12. Same-sex spouses are considered domestic partners.

• **Employee** means someone working under a collective bargaining agreement with a contributing employer. Employee may include a full-time Fund employee, office and clerical employee and duly elected or appointed officer of the Union or an Affiliated Local if the respective Fund, Union or Affiliated Local is a contributing employer.

• **Qualified Medical Child Support Order (QMCOSO)** is a court order that requires an employee to provide medical coverage for his or her children in situations involving divorce, legal separation or a paternity dispute.

• **Spouse** refers to a partner to whom you are legally married under state and federal law.

• **Union** means the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada.
Who Is Eligible

You are eligible to participate in Plan C if:

- you work in covered employment, and
- contributions equal to $150 (required to help cover administrative costs) plus one month’s charge for Plan C-2 single coverage have been received by the Fund from your employer(s).

If you are eligible for coverage under Plan C, your dependents may also be eligible. When you enroll a dependent, you will be asked to provide proof of dependent status, such as a marriage, birth or adoption certificate. Failure to provide documents for your dependents will result in denial of benefits. If you are enrolling in Plan C-MRP, dependent documents also need to be submitted. Eligible dependents include:

- the spouse to whom you are legally married or your domestic partner (as defined on page 12)
- your children, regardless of marital, financial dependency or student status, through the end of the calendar year in which they turn age 26. Children are your natural children, stepchildren, children required to be recognized under a Qualified Medical Child Support Order (QMCSO) and adopted children (including a proposed adopted child during a waiting period before finalization of the child’s adoption.) A foster child is not included.
- unmarried dependent children over age 26 who are unable to do any work to support themselves because of a physical handicap or mental illness, developmental disability or mental retardation, as supported by a Social Security disability award. The incapacity must have started before the child reached age 19, and proof that the dependent continues to be eligible for Social Security disability benefits may have to be provided periodically. Initial written proof of the child’s disability must be submitted to the Fund Office within 31 days after the child’s 19th birthday. Coverage under this extension ends if the dependent child marries or becomes able to earn a living.

When you enroll a dependent, you will be asked to provide proof of dependent status—for example, a marriage, birth or adoption certificate.

Note that the Fund covers a newborn child of any covered individual for the first 30 days of life, provided the Fund Office receives your request to cover the newborn along with a birth certificate within 30 days of the child’s birth. However, if the newborn’s parent is your unmarried covered dependent, coverage cannot be extended beyond 30 days, since the child is not an eligible dependent under the Plan.
If you are already enrolled in family coverage but fail to enroll the newborn within 30 days of the child’s birth, you can enroll your newborn as of the first day of the month following the date that your request (including the child’s birth certificate) is received by the Fund Office. If you are enrolled in single coverage and wish to cover your newborn, you must convert to and pay for family coverage starting with the first day of the month following the child’s birth. If you fail to enroll your dependent (and, if necessary, convert to family coverage) within 30 days, you must wait until the next Annual Enrollment to enroll the child, except under the Special Enrollment rules described on page 37.

Adopted children are covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier. A child is “placed for adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is adopted or placed for adoption with you within 30 days after the child was born will be covered from birth, provided the Fund Office receives your request to cover the child along with a birth certificate within 30 days of the child’s birth, and you either are enrolled in family coverage or convert to and pay for family coverage starting with the first day of the month following the child’s birth.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. Orders must be submitted to the Plan Administrator, who will determine whether the order is a QMCSO as required under federal law. You or your beneficiary can receive a copy of the Plan’s procedures for handling QMCSOs at no cost by contacting the Fund Office.

The Plan provides benefits according to the requirements of a QMCSO. The Fund Office will notify affected participants and alternate recipients if a QMCSO is received.
**Domestic Partnerships**

*Domestic partners* are defined under the Plan as two same sex adults, neither of whom is married (to anyone other than the domestic partner) or legally separated, who either:

- resided with each other for at least six months prior to the application for benefits and who intend to live continuously with each other indefinitely, or

- were legally married in a state or country legalizing same-sex marriage or same-sex civil unions.

In addition, to be recognized as *domestic partners*, the two adults must:

- not be related by blood or in any manner that would bar marriage in their state of residence, and

- be financially dependent on each other, and

- have an exclusive, close and committed relationship with each other, and

- not have terminated the domestic partnership (or same-sex marriage or same-sex civil union).

To cover a *domestic partner* under Plan C, you must apply for coverage for your *domestic partner*. In addition, you must satisfy one of the two following requirements:

- You must submit to the Fund Office a certificate of registration, civil union or marriage. If you live in an area that offers registration of *domestic partners* (such as New York or San Francisco), you must register as *domestic partners* and submit the registration to the Fund Office; or

- You must submit to the Fund Office a notarized Affidavit of Domestic Partnership and a notarized Statement of Financial Interdependence (available at [www.iatsenbf.org](http://www.iatsenbf.org) or from the Fund Office). You will be required to demonstrate financial interdependence by submitting proof of two of the following:

  - a joint bank account (statement, check or passbook with both names)
  
  - a joint credit card account (statement with both names)
  
  - a joint loan obligation (note or other loan origination document with both names)
  
  - joint ownership of a residence (deed or other sale/transfer document with both names, property or water tax document with both names)
  
  - a joint lease of a residence (lease with both names)
  
  - common household expenses (phone, electric bills with both names, public assistance document with both names)
  
  - joint ownership of a vehicle (title in both names)
– joint wills (copy of will or wills, with each party naming the other as beneficiary and/or executor)

– power of attorney (copies of powers of attorney with each party naming the other party and no limitation on the term of the documents)

– health care proxies (copies of health care proxies/living wills, with each party giving the other party the power to make health care/non-resuscitation decisions upon incapacitation)

– life insurance (copy of policy with one party naming the other as beneficiary)

– retirement benefits (copy of beneficiary designation form with one party designating the other as beneficiary).

Proof of the ongoing nature of the domestic partnership may be requested annually.

If you are providing Plan C coverage for a domestic partner and your domestic partnership ends for any reason, you must immediately file a written notice of dissolution of the domestic partnership with the Fund Office.

In the event a participant dies while enrolled in Plan C-1 or Plan C-2, his or her domestic partner would not be entitled to the life insurance benefit available to participants enrolled in Plan C-1 or Plan C-2 unless the domestic partner is listed on the life insurance beneficiary designation form as the participant’s beneficiary. Additional information on the life insurance benefit can be found on page 113.

All or part of domestic partner health coverage may be considered taxable income under federal and/or state tax rules unless you self-pay for the coverage. More tax information is included on the domestic partner application. However, you and your domestic partner should consult with a personal tax advisor on the tax implications of such coverage. The Fund cannot be responsible for any tax or other financial effects associated with domestic partner coverage.

Please note that eligibility may be terminated retroactively or you may lose benefits if you fail to notify the Fund Office in writing within 30 days of a change in family status. In addition, if you or your dependents fail to submit any requested or required information or proof to the Fund Office, make a false statement material to a claim, or furnish fraudulent or incorrect information material to a claim, benefits under the Fund may be denied, suspended or discontinued, as appropriate. The Fund has the right to recover any excess benefit payments made in reliance on any false or fraudulent information or proof submitted by you or your dependents, including failure to immediately advise the Fund of changes to information already provided.
Your CAPP Account

Terms You Should Know...

• **CAPP (Contributions Available for Premium Payments) account** refers to an account in your name that tracks the amount of employer contributions received on your behalf for coverage under Plan C.

• **Combining CAPP accounts** refers to a provision under Plan C that allows two Plan C participants who are married or domestic partners to direct employer contributions received on behalf of either of them to a single account.

• **Coverage quarter** refers to three consecutive months of a calendar quarter (January-March, April-June, July-September, October-December) during which you are enrolled in Plan C.

• **Employer contributions** are amounts that employers contribute to the Health & Welfare Fund on behalf of employees who are covered by the IATSE National Health & Welfare Plan C.

• **Uncombining CAPP accounts** refers to a provision under Plan C that allows two Plan C participants to separate a combined account into two individual accounts.

IATSE or its Affiliated Locals negotiate employer contribution rates that may be stated as dollars per hour, day, week or month or as a percentage of pay. The first $150 in employer contributions received on your behalf for work in covered employment is used to defray Fund administrative costs. This administrative fee will be charged every time you enter or reenter the Plan. If you enroll solely in Plan C-MRP, there is an additional annual fee (see page 21). After that, all employer contributions received on your behalf go into a CAPP (Contributions Available for Premium Payments) account in your name. Your CAPP account balance determines:

• when you become eligible for health care coverage, and

• how much (if anything) you must contribute (self-pay) toward the cost of your coverage each coverage quarter.

CAPP accounts are notional accounts maintained for Plan participants. CAPP accounts and CAPP account balances are not vested benefits. Your CAPP account may also be decreased if the Fund determines that employer contributions were credited to your account by mistake. The Trustees reserve the right to change CAPP account requirements and/or balances at any time.

You cannot contribute to your CAPP account. Employer contributions based on work performed in covered employment are the only amounts credited to your CAPP account. If you make a self-payment, and you pay more than is needed, the excess payment will be refunded to you. It will not be held in your account for future use.
Keeping Track of Your CAPP Account Balance

If you are a Plan C participant, you have 24/7 access to personalized information about your employment history and contributions received on your behalf by your employer(s)—both online and by telephone.

You can view your CAPP account balance and work history online (as far back as a year or more). If you have a computer with internet access, simply follow these steps to set up a personal and confidential account:

- Log on to www.iatsenbf.org and click “Participant.”
- Under “Participant Access” on the left side of the page, click “Create New Account.”
- Enter the requested information. After you complete your registration, you can log on at any time by clicking “Log In” under “Participant Access” and entering your username and password.

If you do not have access to a computer with internet access, you can use the toll-free interactive voice response (IVR) system, which is also available 24 hours a day. Simply call 1-800-456-FUND (3863). The IVR system uses voice recognition technology to give you immediate confidential access to personal information about your Fund benefits—including your CAPP account balance.

Participants currently enrolled in any of Plan C’s coverage options receive a quarterly CAPP statement that shows a current balance. Be sure to review your statements carefully.

Combining and Uncombining CAPP Accounts

If your legal spouse or eligible same-sex domestic partner is also a Plan C participant, employer contributions may be combined into a single CAPP account. This combination of CAPP accounts requires written authorization from both participants. You can find a Combined CAPP Account Request Form at www.iatsenbf.org.

Your accounts will be combined at the start of the next coverage quarter provided the Fund Office received a completed Request Form signed by both parties by the due date for participant self-payments for that quarter. (See page 33 for the due dates for each coverage quarter.) Otherwise, the combining will occur as of the first of the following coverage quarter. For example, if the Request Form is received on December 15, the combining will occur on January 1. However, if the request Form is received on December 20, the combining will not occur until April 1.
When you combine your accounts, you must designate one participant as the primary participant for the combined account and the other participant as the secondary, who will be considered a dependent of the primary participant. Only the primary participant will be covered under the Plan’s life insurance policy.

If you and your spouse or same-sex domestic partner have employer contributions combined into a single CAPP account, you have the option to separate them back into two individual accounts (known as “uncombining”). If you opt to uncombine, the primary participant will be changed to a single policy under the same Plan C option if no other dependents are listed. The secondary account holder will be sent a statement and given the opportunity to elect and self-pay for any option under Plan C for which he or she is eligible. The Fund determines how much is transferred to each of your accounts based on the proportion of employer contributions received on behalf of each of you over the most recent 12 months. The uncombining will take effect as of the start of the next coverage quarter following receipt of a written request, provided that such request is received 30 days prior to the start of that coverage quarter. For example, if your request is received on March 1, the uncombining will occur on April 1. However, if it is received on March 30, the uncombining will not occur until July 1.
Initial Participation

Terms You Should Know...

- **Optional enrollment** refers to your first opportunity to enroll in Plan C, which occurs when contributions to your account are sufficient to cover the $150 administrative fee plus the current monthly charge for Plan C-2 single coverage.

- **Automatic enrollment** occurs if you do not enroll during optional enrollment and contributions to your account are sufficient to cover the $150 administrative fee plus the current quarterly charge for Plan C-2 single coverage.

- **Employer contribution period** refers to the three consecutive months during which contributions received by the Fund Office on your behalf are applicable to a particular coverage quarter. For example, contributions received from August through October are applicable to the coverage quarter from January through March.

- **Plan C-MRP (Medical Reimbursement Program)** is an option under Plan C that helps you pay for health care expenses in one of two ways. If you provide acceptable proof that you have other medical coverage that complies with the Affordable Care Act, you can enroll in Plan C-MRP as a **standalone option** and use your entire account balance for eligible medical expenses. If you enroll in Plan C-1, C-2 or C-3 and there is “excess” funding in your **CAPP account**, you can use Plan C-MRP as a **supplemental option** for eligible medical expenses. Excess funding refers to any amount in your account as of the end of the applicable **employer contribution period** that exceeds the cost of your coverage for the current and subsequent coverage quarter.

- **Self-payments** are quarterly payments you make toward the cost of your health care coverage if employer contributions to your **CAPP account** are insufficient for coverage or for the level of coverage you want.

The earliest you can participate in the Health & Welfare Fund Plan C is when you become eligible for what is known as optional enrollment. If you do not enroll at that time, you will have another opportunity to enroll when you become eligible for automatic enrollment. If you waive optional enrollment and fail to choose a coverage option when you become eligible for automatic enrollment, you will be enrolled automatically in the Plan’s default option, which is Plan C-2 single coverage.
Optional Enrollment

You are entitled to optional enrollment when your CAPP account balance equals the current monthly charge for Plan C-2 single coverage plus the $150 administrative fee described on page 14. When you become eligible for optional enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form. If you enroll, your coverage will begin on the first day of the next coverage quarter.

When you become eligible for optional enrollment, you will have the following choices for medical coverage:

- Plan C-1 (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost
- Plan C-2 (single or family coverage), which provides in-network and out-of-network coverage at a lower cost than Plan C-1
- Plan C-3 (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2
- Plan C-MRP (Medical Reimbursement Program), if you provide acceptable proof that you have medical coverage from another source that complies with the Affordable Care Act—for example, through your spouse’s employer. (See page 24 for more information about Plan C-MRP)
- waive coverage entirely. If you waive coverage, you will not have another opportunity to enroll in Plan C until you become eligible for automatic enrollment.

You will be required to self-pay a portion of the cost of coverage if your available employer contributions are insufficient to cover the cost of the coverage you elected. See page 23 for more about self-paying.
If you enroll and submit any required documentation or self-payment by the deadline indicated on the CAPP Statement and Enrollment/Payment Form, your coverage will take effect as of the first day of the following coverage quarter after your enrollment materials are due to the Fund Office’s designated mailing address, as follows:

<table>
<thead>
<tr>
<th>IF CONTRIBUTIONS REQUIRED FOR ENROLLMENT ARE RECEIVED BY THE FUND OFFICE BY</th>
<th>THE FUND OFFICE WILL MAIL YOUR CAPP STATEMENT AND ENROLLMENT/PAYMENT FORM IN</th>
<th>YOUR ENROLLMENT MATERIALS AND SELF-PAYMENT (IF REQUIRED) WILL BE DUE AT THE FUND OFFICE BY</th>
<th>YOUR COVERAGE WILL BEGIN ON THE FIRST DAY OF THE COVERAGE QUARTER THAT BEGINS IN</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 31</td>
<td>mid-November</td>
<td>December 15</td>
<td>January</td>
</tr>
<tr>
<td>January 31</td>
<td>mid-February</td>
<td>March 15</td>
<td>April</td>
</tr>
<tr>
<td>April 30</td>
<td>mid-May</td>
<td>June 15</td>
<td>July</td>
</tr>
<tr>
<td>July 31</td>
<td>mid-August</td>
<td>September 15</td>
<td>October</td>
</tr>
</tbody>
</table>

When you enroll for family coverage, coverage for your dependents begins on the same date that your coverage starts, provided that the Fund receives a request to enroll each dependent with proof of dependent status (e.g., marriage or birth certificate). If you are enrolled in family coverage and acquire a dependent after you enroll, that dependent will be covered when he or she first becomes your dependent, provided that the Fund Office receives a request to enroll the dependent with proof of dependent status (e.g., marriage or birth certificate) within 30 days of the date he or she became your dependent.

If you do not enroll your dependent on time and are enrolled in family coverage, you may enroll your dependent as of the first of the month after the Fund receives a request to enroll the dependent and proof of dependent status. If you are enrolled in single coverage, and you do not enroll your dependent (and convert to and pay for family coverage) within 30 days, you must wait until the next Annual Enrollment period to change to family coverage and enroll your dependent. Note that special circumstances (described on page 37) may allow you to enroll earlier.
Automatic Enrollment

If you choose to waive coverage when you become eligible for optional enrollment, you cannot enroll until you become eligible for automatic enrollment. You are entitled to automatic enrollment when your CAPP account balance equals the current quarterly charge for Plan C-2 single coverage. If you waived optional coverage and become eligible for automatic enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

If you do not make an election when you become eligible for automatic enrollment, you will be enrolled automatically in Plan C-2 single coverage.

You have the following choices when you become eligible for automatic enrollment:

- Plan C-1 (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost
- Plan C-2 (single or family coverage), which provides a lower level of in-network and out-of-network coverage at a lower cost than Plan C-1
- Plan C-3 (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2
- Plan C-MRP (Medical Reimbursement Program), if you provide acceptable proof that you have medical coverage from another source that complies with the Affordable Care Act—for example, through your spouse’s employer. (See page 24 for more information about Plan C-MRP)

You cannot waive coverage once you become eligible for automatic enrollment.

Refer to Plan Highlights on pages 1-8 for a comparison of benefits under Plan C-1, Plan C-2 and Plan C-3.

Depending on your coverage election, you may be required to self-pay a portion of the cost of coverage. See page 23 for more information about self-paying.

If you do not make an election when you become eligible for automatic participation, you will be enrolled automatically in Plan C-2 single coverage. (Participants in Puerto Rico will be enrolled automatically in single coverage under the Triple-S PPO or other equivalent plan.)
If you enroll and submit any required documentation or self-payment by the deadline indicated on the CAPP Statement and Enrollment/Payment Form, your coverage will take effect as of the first of the following coverage quarter after your enrollment materials are due to the Fund Office’s designated mailing address, as shown in the chart on page 19. When you enroll for family coverage, coverage for your dependents generally begins on the same date that your coverage starts or, if later, when they first become your dependents, provided that you enroll them within 30 days of the date they became your dependents.

Enrollment Summary
The following chart summarizes the rules for initial participation in the Health & Welfare Fund Plan C.

<table>
<thead>
<tr>
<th>IF EMPLOYER CONTRIBUTIONS ON YOUR BEHALF EQUAL</th>
<th>THEN</th>
<th>YOUR ENROLLMENT OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than the total of $150 plus the monthly charge for Plan C-2 single coverage</td>
<td>You do not yet meet the requirements for participation.</td>
<td>You are not yet eligible to enroll.</td>
</tr>
<tr>
<td>At least $150 plus the monthly charge for Plan C-2 single coverage</td>
<td>You meet the requirements for optional enrollment.</td>
<td>You can enroll in Plan C-1, C-2, C-3, C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant) or waive coverage entirely.</td>
</tr>
<tr>
<td>At least $150 plus the quarterly charge for Plan C-2 single coverage</td>
<td>You meet the requirements for automatic enrollment.</td>
<td>You can enroll in Plan C-1, C-2, C-3 or C-MRP as a standalone option (with acceptable proof of other medical coverage that is Affordable Care Act compliant). If you do not enroll, you will be enrolled automatically in Plan C-2 single coverage.</td>
</tr>
</tbody>
</table>

Choosing Plan C-MRP (Medical Reimbursement Program) as a Standalone Option
If you have other health care coverage (for example, under a spouse’s employer’s plan), you may enroll in Plan C-MRP as a standalone option. By choosing this option, your CAPP account balance can be used to pay certain expenses. An annual $150 administration fee (different from the $150 fee for new participants described on page 14) will be deducted from your CAPP account each November if you were enrolled in Plan C-MRP at any point during the current calendar year. If you have less than $150 in your CAPP account at the time the fee is deducted, the balance in your account will be applied toward administrative expenses.
If you are covered under Plan C-MRP and involuntarily lose your eligibility for other health care coverage under another plan, you can transfer into Plan C-1, C-2 or C-3. If you provide the Fund Office with proof of your loss of coverage within 30 days after the loss, your new coverage under Plan C-1, C-2 or C-3 can take effect the first day of the next calendar month. If you provide the Fund Office with proof of your loss of coverage more than 30 days after the loss, your new coverage under Plan C-1, C-2 or C-3 will not take effect until the start of the coverage quarter after the Fund Office receives the proof of loss. If you fail to choose Plan C-1, C-2 or C-3, you will be enrolled automatically in Plan C-2 single coverage. However, if the funds in your CAPP account are not sufficient for Plan C-2 single coverage, your coverage will lapse, and you will not be eligible to reenroll until the balance in your CAPP account equals the monthly charge for Plan C-3 single coverage plus the $150 administrative fee.

Alternatively, if you are covered under Plan C-1, C-2 or C-3 and become eligible for acceptable coverage elsewhere (for example, through a spouse’s employer’s plan), you can submit a written election form to transfer into Plan C-MRP. The transfer will take effect the first day of the next coverage quarter after the Fund Office receives acceptable proof of your other coverage.

A detailed description of Plan C-MRP begins on page 24, including how to enroll in the standalone option.

If you enroll in Plan C-MRP as a standalone option, you must submit proof of other acceptable coverage to the Fund Office every year during Annual Enrollment.

If you were enrolled in Plan C-MRP at any point during the current calendar year, a $150 administrative fee will be deducted from your CAPP account during Annual Enrollment regardless of your effective date.
**Self-Payments**

Once you become enrolled in Plan C, *employer contributions* are deducted from your *CAPP account* prior to each *coverage quarter* to pay for your coverage. However, your coverage option may require a quarterly contribution that exceeds the amount in your *CAPP account*. In such a case, you may pay the difference by making a *self-payment*.

The Fund Office will mail you a statement quarterly (the chart on page 33 shows the approximate mailing dates) indicating your *CAPP account* balance, your current coverage choice, your coverage options (if applicable) and any *self-payment* that may be required. **You are responsible for this payment whether or not you actually receive your statement.**

That’s why the Fund provides a number of resources for you to track your balance, know what payment may be due and understand your payment options. The chart on page 33 shows when each quarterly payment (if required) is due. You can also find or confirm this information by contacting the Fund Office, logging on to [www.iatsenbf.org](http://www.iatsenbf.org) or calling the interactive voice response (IVR) system.

---

Managing your account is vital to ensure that important health care protection continues for you and your family. We encourage you to frequently monitor your account and payments due, just as you would with any other account in your name.

---

*Self-payments* must be made by the deadline indicated on your *quarterly CAPP statement*. The consequences of failing to *self-pay* the required amount on time are described on page 34.
Plan C-MRP (Medical Reimbursement Program)

Plan C-MRP (Medical Reimbursement Program) provides reimbursement for qualifying medical expenses. Depending on your individual circumstances, you can participate in Plan C-MRP in one of two ways:

- If you provide proof that you have other coverage and certify that it is compliant with the Affordable Care Act, you can enroll in Plan C-MRP as a standalone option instead of Plan C-1, C-2 or C-3.

- If you enroll in Plan C-1, C-2 or C-3 and have excess funds (defined on page 27) in your CAPP account, you can use Plan C-MRP as a supplement to your Plan and be reimbursed for qualifying expenses that are not covered by your Plan.

- You may claim reimbursement for your eligible dependents if you enroll them with the Fund. Unless you enroll your dependents when you start coverage, your dependents will be enrolled under Plan C-MRP as of the first day of the month following the date the Fund receives your request to enroll them in Plan C-MRP along with proof of the dependent status. You will not be reimbursed for your dependents’ expenses incurred prior to the date they are enrolled in Plan C-MRP.

Requirements for participating and the amount of your CAPP account available for reimbursement depend on whether you elect Plan C-1, C-2, C-3 or Plan C-MRP as your primary option.

Enrolling in Plan C-MRP as a Standalone Option

If you have proof of other medical coverage (such as through your spouse’s employer), you can choose to enroll in Plan C-MRP as a standalone option when you become eligible for Plan C. If you are enrolled in Plan C-MRP, you can use your entire CAPP account balance as of the applicable employer contribution period for reimbursement of qualifying medical expenses (subject to the administrative charge described on page 21). You must be enrolled in Plan C-MRP both when the expense is incurred and when you submit a claim for reimbursement.
To enroll in Plan C-MRP as a standalone option, you must return your completed Plan C CAPP Statement and Enrollment/Payment Form, submit a copy of your medical ID card from another plan and sign the certification on the Form (section B) that your other plan is in compliance with the Affordable Care Act. In addition, every year you must provide valid proof of other medical coverage and certify that your other plan is compliant with the Affordable Care Act during each Annual Enrollment period for as long as you remain enrolled in Plan C-MRP as a standalone option. You may also enroll your eligible dependents in Plan C-MRP. Unless you enroll your dependents when you start coverage, your dependents will be enrolled under Plan C-MRP as of the first day of the month following the date the Fund receives your request to enroll them in Plan C-MRP along with proof of the dependent status. You will not be reimbursed for your dependents’ expenses incurred prior to the date they are enrolled in Plan C-MRP.

You must also enroll your dependents and provide proof of their dependent status if you want to be reimbursed for their qualifying medical expenses.

If you do not provide proof of other coverage by the enrollment deadline for automatic enrollment or each year during Annual Enrollment, you will be enrolled automatically in single coverage under Plan C-2 or C-3, depending upon your CAPP account balance when statements are generated, and the charge for such coverage will be deducted from your CAPP account. If you later submit proof of other medical coverage, you will be enrolled in Plan C-MRP as of the start of the next coverage quarter following the Fund’s receipt of such proof. You will not receive a refund for the cost of coverage of Plan C-2 or C-3 prior to your enrollment exclusively in Plan C-MRP. If your balance is insufficient for single coverage under Plan C-3, you will not have any coverage under Plan C. You will have lapsed out of coverage and will have to requalify for coverage under the Plan’s eligibility rules, which means that you will not again be eligible for any coverage until you have eligible employer contributions in your CAPP account equal to at least one month of Plan C-3 single coverage plus the $150 administrative fee. Ordinarily, the Fund requires a copy of your insurance card as proof of your other coverage. However, if you have not received a copy of your insurance card by the Fund’s deadline, you must submit other written confirmation from your other coverage that you are covered under that Plan and detailing the dates of such coverage. You must submit, to the Fund Office, the copies of your insurance cards once they are issued to you to remain enrolled in Plan C-MRP.
If You Are on Medicare. In order to comply with government rules regarding Medicare, you will only be permitted to be enrolled in Plan C-MRP as a standalone option if you are no longer active. If you are active, the Fund cannot accept Medicare as other coverage under Plan C-MRP; you must enroll in Plan C-1, C-2, or C-3, or you will be defaulted into Plan C-3 in accordance with Plan rules. The Fund will consider you active for a particular coverage quarter if:

- you have received any contributions in the applicable employer contribution period for that coverage quarter (for example, August–October for the following January–March), and

- your CAPP account equals or exceeds the quarterly cost for Plan C-3 single coverage. Your CAPP account will be reviewed each quarter. You will remain in the coverage you elected or defaulted into for as long as you are considered active. If you are no longer considered active and a balance remains in your CAPP account, you will have the option to continue in the coverage you elected or be reenrolled in Plan C-MRP. If you do not respond and are no longer active, you will be automatically reenrolled in Plan C-MRP.

Option to Waive Coverage for those on Medicare. If you are on Medicare and you are deemed to be an “active” employee, you have the option to enroll in Plan C-1, C-2 or C-3 or waive coverage by completing the Plan C waiver form. If you are offered coverage under Plan C-1, C-2 or C-3, you may elect to waive coverage by timely submitting your quarterly election form along with a “Refusal of Health Coverage” form to the Fund Office. Such election is due at the time all other quarterly election forms are due (i.e., the 15th of the month prior to the start of the coverage quarter). If you timely waive coverage, you will forfeit your entire CAPP account balance as of the last day of the applicable employer contribution period (e.g., as of January 31 for a waiver of coverage effective for the April 1 coverage quarter). This date shall be your forfeiture date. Any employer contributions received by the Plan after that forfeiture date shall be credited to your CAPP account based on the Plan’s rules.

If you were previously enrolled in Plan C (including Plan C-MRP), your coverage will be treated as if it lapsed, and you will be offered voluntary enrollment only once your CAPP account equals or exceeds the cost of one month of Plan C-3 single coverage, plus the $150 administrative fee. If you were not previously covered by the Plan, you must re-qualify under the Plan’s optional enrollment rules to be eligible for Plan coverage in the future. If, based on contributions received after your forfeiture date, you again become an “active” participant eligible for coverage, you must again either elect coverage, or waive coverage by timely submitting your quarterly election form along with a “Refusal of Health Coverage” form to the Fund Office. Any such waiver will, once again, cause the forfeiture of any newly acquired CAPP account balance. If you do not timely waive or elect coverage, you will be defaulted into Plan C-3 coverage in accordance with the Plan’s rules.
Participating in Plan C-MRP as a Supplement to Plan C-1, C-2 or C-3

If you and your eligible dependents are enrolled in Plan C-1, C-2 or C-3, you are automatically eligible to participate in Plan C-MRP as a supplement to your Plan, provided you have sufficient funds in your account. Plan C-MRP allows you to use “excess funds” in your CAPP account to pay medical, prescription drug, dental and vision expenses that are not paid by the Plan (subject to the administrative charge described next). “Excess funds” means any amount in excess of what is needed to pay the current and next quarter’s CAPP charges for the medical coverage in which you are enrolled (Plan C-1, C-2 or C-3). For example, assume you are enrolled in Plan C-2 single coverage and want to submit a claim for reimbursement in January. Your excess funds would be based on your CAPP account balance as of the prior October 31 (the end of the employer contribution period for the current coverage quarter) and would equal the amount in the account that exceeds the cost of two quarters of Plan C-2 single coverage. Keep in mind also that excess funds can be used only for expenses that are incurred while you are covered under the Plan.

If you are enrolled in single coverage (under Plan C-1, C-2 or C-3), you need to enroll your eligible dependents in Plan C-MRP in order to be eligible for reimbursements of those dependents’ expenses. Unless you enroll your dependents in Plan C-MRP when you start coverage, your dependents will not be enrolled under Plan C-MRP until the first day of the month following the date the Fund receives your request to enroll them in Plan C-MRP along with proof of the dependent status. You will not be reimbursed for your dependents’ expenses incurred prior to date they are enrolled in Plan C-MRP.

The Medical Reimbursement Program is administered by Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS). If you have any questions about the program, contact ASO/SIDS at 1-516-396-5525 (in NY) or 1-877-390-5845 (outside NY).

Administrative Charge

Whether you are enrolled in Plan C-1, C-2, C-3 or C-MRP, each time you submit a claim for reimbursement, an administrative charge equal to a percentage of the claim will be deducted from your CAPP account. The percentages in 2012 (subject to change) are as follows:

<table>
<thead>
<tr>
<th>AMOUNT OF CLAIM ELIGIBLE FOR REIMBURSEMENT AS % OF CLAIM</th>
<th>ADMINISTRATIVE CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1–$249</td>
<td>5.0%</td>
</tr>
<tr>
<td>$250–$499</td>
<td>4.5%</td>
</tr>
<tr>
<td>$500–$999</td>
<td>3.5%</td>
</tr>
<tr>
<td>$1,000–$1,999</td>
<td>2.5%</td>
</tr>
<tr>
<td>$2,000 or more</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Qualifying Expenses

Medical expenses that can be reimbursed under Plan C-MRP can be either:

- expenses that are not paid in full under your Plan C-1, C-2, C-3 or other medical coverage, or
- your cost of premiums for qualified medical coverage other than that provided by Plan C-1, C-2 or C-3 (for example, a medical insurance policy you purchased on your own that includes coverage for you or the cost of coverage for you and your family under your spouse’s employer-provided medical coverage).

In order to qualify for reimbursement under Plan C-MRP, a health care expense must meet all of the following requirements:

- It is incurred after the effective date of your coverage.
- It is on one of the lists of qualifying expenses that appear later in this section.
- It has not been and will not be reimbursed by Plan C-1, C-2, C-3 or any other coverage.
- It is submitted with appropriate documentation, including:
  - a detailed statement or bill that includes the name, address, phone number and tax ID number of the provider; the patient’s name, address, birth date and relationship to the member; and an itemization and description of the service(s) provided
  - a copy of an Explanation of Benefits (EOB) or other statement from an insurance company or other provider showing denial of reimbursement or proof that the expense is not reimbursable.
- It must be rendered by a licensed provider, in accordance with applicable law.

In addition, the claim sent to ASO/SIDS must be postmarked by the March 31 following the calendar year in which the health expense was incurred.

There are two types of qualifying expenses under Plan C-MRP: qualifying medical coverage premiums and qualifying unreimbursed medical expenses.

**Qualifying medical coverage premiums.** To qualify for reimbursement, medical premiums must satisfy all of the following requirements:

- The medical policy or plan must provide you or you and your dependents with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc. (Premiums that do not include you in the coverage do not qualify for reimbursement except that the Fund will reimburse your spouse’s Medicare premiums even if you are not eligible for Medicare.)
- The premium must have been paid after your plan coverage took effect.
- The premium must cover a policy that is in effect at the time reimbursement is to be paid.
• The claim must be postmarked by the March 31 following the calendar year in which the premiums were payable.

• The claim must be documented with proof of payment and a description of the medical coverage provided (for example, a premium billing statement and canceled check). In the case of coverage through your spouse’s employer, you will be asked to provide proof that an additional premium was paid for your coverage.

Premiums for life insurance, accidental death and dismemberment insurance, loss of income insurance or automobile insurance are not eligible for reimbursement.

To be eligible for reimbursement under Plan C-MRP, your expense must be a qualifying medical coverage premium or appear on the list of qualifying unreimbursed medical expenses.

Qualifying unreimbursed medical expenses. Unreimbursed medical expenses that qualify for reimbursement include:

• legal abortions

• acupuncture (limited to 14 visits per calendar year)

• alcohol/substance abuse treatment (reimbursement limited to 30 days on an inpatient basis and 50 outpatient visits)

• ambulance (to and from hospital only)

• ambulette (to and from a medical facility only)

• annual physical exam (limited to one exam per calendar year)

• artificial limbs

• artificial teeth

• birth control pills (must be prescribed by a doctor)

• chiropractors (limited to 40 visits per calendar year)

• Christian Science practice

• corrective optical laser surgery

• cosmetic surgery (only if necessary to improve a deformity arising from, or directly attributable to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease)
• durable medical equipment, such as crutches and wheelchairs (reimbursement for rental fee may not exceed purchase price)

• deductibles, copays and coinsurance payments under your medical coverage

• dental treatment

• diapers/diaper service (must be for a person three years of age or older and required to relieve the effects of a particular disease)

• eyeglasses (maximum reimbursement of one eye examination and two pairs of lenses and frames or contact lenses per calendar year). No benefits are payable for lenses or frames that are not prescribed by an ophthalmologist or an optometrist.

• laboratory fees

• long-term care insurance policy premiums, subject to certain IRS limitations

• medicine (prescription drugs, medications and insulin)

• nursing services (must be for services connected with caring for the patient’s condition, such as giving medication or changing dressings). Services must be rendered by a registered nurse (RN), licensed practical nurse (LPN) or health aide who reports to a licensed or certified home health care agency. (Benefits are not available for services rendered by immediate family members or someone who ordinarily lives in your home.)

• operations (expenses must be for legal operations)

• oxygen

• psychiatric care, psychoanalysis and psychologists (reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year, subject to review)

• sterilization

• physical, occupational, cardiac and speech therapy as ordered by a qualified physician and performed by the appropriate licensed therapist

• transplants

• well baby care (reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year, subject to review)

• x-rays, MRIs and similar diagnostic procedures ordered by a qualified physician

• hearing aids and repairs and batteries for a hearing aid

• vision therapy for enrolled dependent children as ordered by a qualified physician and performed by the appropriate licensed therapist for treatment related to a neurological disorder. Neurological disorders may include, but are not limited to, amyotrophic lateral sclerosis, cerebral palsy, epilepsy, Parkinson’s disease, muscular dystrophy, multiple sclerosis, spastic paraplegia and Tourette’s syndrome.
Claiming Reimbursement

Plan C-MRP claims submitted with all required information are generally processed within 30 days of receipt by ASO. If you do not submit Plan C-MRP claims with all required information, then the processing of such claims may be delayed. How you file your claim depends on which type of claim you are making—for a health care insurance premium or for an expense that is not covered in full under your health care coverage.

For a premium. Once your premium for other insurance has been paid, you may apply for reimbursement, as follows:

• Obtain a Plan C-MRP claim form online at www.iatsenbf.org or from the Fund Office.

• Fill out the claim form and attach a copy of the premium statement and proof of payment (for example, a canceled check or pay stubs that show the payment of your premiums by means of payroll deductions). The form should be signed and returned to:
  
  ASO/SIDS
  
  P.O. Box 9005, Dept. 51
  
  Lynbrook, NY 11563-9005

• You may be asked to also furnish a statement from the employer that provides your medical coverage (for example, your spouse’s employer).

• The claim must be postmarked by the March 31 following the calendar year in which the premiums were payable.

For an unreimbursed medical expense. After all the medical plans under which you’re covered have considered a claim and you have received an Explanation of Benefits (EOB) from each of them, you may apply to Plan C-MRP for any unreimbursed balance of your expense. Reimbursement will be made only to you, not to an insurance company or a medical provider. Do not file a claim if your expense is covered in full by any combination of sources or if it is not a qualifying expense. (See the list of qualifying expenses earlier in this section.) To file your claim:

• Obtain a Plan C-MRP claim form online at www.iatsenbf.org or from the Fund Office.

• Fill out the claim form and attach a copy of the itemized bill for the qualifying expense and the corresponding EOBs for each claim. This form should be signed and returned to:
  
  ASO/SIDS
  
  P.O. Box 9005, Dept. 51
  
  Lynbrook, NY 11563-9005

• The claim must be postmarked by the March 31 following the calendar year in which the service was performed or the item was provided.

• You must file separate completed, signed and dated forms for each family member.

In no event is reimbursement allowed for any expense that is not deductible from income as a medical expense under the Internal Revenue Code.
Continuing Participation

Terms You Should Know...

- **Automatic downgrade** is an automatic reduction in your coverage if the coverage you want requires a self-payment and you fail to make the payment (or it is received after the applicable deadline).

- **Coverage lapse** refers to a termination of all coverage under the Plan because your CAPP account balance is insufficient to cover the quarterly cost of the lowest-cost option and you fail to make a timely self-payment.

- **Forfeiture** is what happens if there is no activity in a CAPP account for two consecutive calendar years. The balance in the account is forfeited.

- **Participation termination** means you lose your eligibility for participation in Plan C because your CAPP account balance for the next coverage quarter is zero and, over the preceding 24 months, contributions made by employers on your behalf have been less than the quarterly charge for Plan C-2 single coverage.

- **Quarterly CAPP statement** is the report that is mailed to Plan C participants before the start of each coverage quarter for the purpose of electing coverage for that quarter.

Once you become a Plan C participant, before the start of each coverage quarter, you will receive a Plan C quarterly CAPP statement that shows:

- your current enrollment option
- your current CAPP account balance
- coverage options available to you for the next coverage quarter.

The CAPP account balance shown on your statement includes all employer contributions that were received in your CAPP account through the end of the applicable employer contribution period, which is two months prior to the start of the next coverage quarter. (See the chart on page 33). You can keep your current coverage or elect any of the other options listed on your statement. If the balance in your CAPP account is not enough to cover the quarterly charge for the coverage you elect, you will be required to self-pay the difference. The amount you will be required to self-pay will be included on your quarterly statement.

You can keep the same coverage quarter after quarter, or you can voluntarily downgrade your Plan option at the start of any coverage quarter. A downgrade means you drop your current coverage to a lower-cost option. Your options for a downgrade will depend on your coverage at the time of your downgrade and will be included on the Plan C statement you receive each quarter. For example, if you have Plan C-2 family coverage, you can voluntarily downgrade to Plan C-3 family, C-2 single, C-3 single or C-MRP.
You can upgrade your coverage only at the start of a new calendar year during Annual Enrollment—unless you experience a qualifying event (see page 37).

If the balance in your CAPP account is not sufficient to cover the quarterly charge for your coverage, you can self-pay the difference by mailing a check or money order to the Fund Office’s designated mailing address or paying online by credit card (MasterCard or Visa only) at www.iatsenbf.org. If you pay online, keep the confirmation number that you receive from the Web site. If you wish to pay by providing your credit card number to the Fund Office over the telephone, a credit card authorization form must be on file with the Fund Office. In order to accept credit card payments, the card must be issued in the participant’s or spouse’s name. Either way, your payment must be received by the 15th of the month preceding the first day of the applicable coverage quarter (for example, December 15 for the coverage quarter beginning January 1).

You are responsible for ensuring that payment is received by the deadline in order for you to maintain coverage, regardless of whether or not you received a quarterly statement. If you mail a check, be sure to retain proof of mailing (for example, a receipt from UPS or FedEx or a return receipt requested from the U.S. Postal Service). If you pay online, keep the confirmation number that you receive from the Web site. If you want to pay by providing your credit card number to the Fund Office over the telephone, a credit card authorization form must be on file with the Fund Office. In order to accept credit card payments, the card must be issued in the participant’s or spouse’s name. Regardless of how you make the payment, you should check your account online or by telephone to ensure that it was received. Allow adequate time for mail and/or processing. If your account has not been credited with your payment, contact the Fund Office immediately. You will be expected to provide proof of mailing for a check or the confirmation number for an online payment. Remember, if your payment is delayed or lost, you may lose vital coverage for yourself and your family.

The following chart shows the timing for continuing your participation each coverage quarter.

<table>
<thead>
<tr>
<th>EMPLOYER CONTRIBUTION PERIOD</th>
<th>MAIL DATE FOR CAPP ACCOUNT STATEMENT</th>
<th>DEADLINE FOR RECEIPT OF SELF-PAYMENTS</th>
<th>COVERAGE QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1–October 31</td>
<td>mid-November</td>
<td>December 15</td>
<td>January 1–March 31</td>
</tr>
<tr>
<td>November 1–January 31</td>
<td>mid-February</td>
<td>March 15</td>
<td>April 1–June 30</td>
</tr>
<tr>
<td>February 1–April 30</td>
<td>mid-May</td>
<td>June 15</td>
<td>July 1–September 30</td>
</tr>
<tr>
<td>May 1–July 31</td>
<td>mid-August</td>
<td>September 15</td>
<td>October 1–December 31</td>
</tr>
</tbody>
</table>

If you do not receive your quarterly CAPP account statement in advance of the applicable deadline above, you should contact the Fund Office, or access your account online or through the telephone system. Keep in mind, however, that any payment due must be received by the deadline shown above, regardless of whether or not you receive a statement.
Employer contributions must be received by the close of business on the last day of the employer contribution period. If the last day of the employer contribution period is not a normal operating business day, then employer contributions must be received by the close of business on the last business day of the employer contribution period. Employer Contributions (including delinquent contributions) received after the close of business on the last business day of the employer contribution period cannot be used to pay for coverage until the coverage quarter after the employer contribution period in which the employer contributions are received by the Fund Office. For example, employer contributions received in November and December cannot be used for coverage effective January 1. They are held in your account and can be used for coverage effective April 1.

**Automatic Downgrades**

If the coverage you want requires a self-payment and the Fund does not receive your payment by the deadline, or if you are enrolled in Plan C-MRP as a standalone option and the Fund does not receive your proof of other medical coverage during Annual Enrollment, your coverage will be downgraded automatically, as follows:

<table>
<thead>
<tr>
<th>CURRENT ELECTION</th>
<th>C-1 FAMILY</th>
<th>C-2 FAMILY</th>
<th>C-3 FAMILY</th>
<th>C-1 SINGLE</th>
<th>C-2 SINGLE</th>
<th>C-3 SINGLE</th>
<th>C-MRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERAGE DOWNGRADED TO</td>
<td>C-2 Family</td>
<td>C-3 Family</td>
<td>C-3 Single</td>
<td>C-2 Single</td>
<td>C-3 Single</td>
<td>No coverage</td>
<td>C-2 Single</td>
</tr>
<tr>
<td></td>
<td>C-3 Family</td>
<td>C-2 Single</td>
<td>No coverage</td>
<td>C-3 Single</td>
<td>No coverage</td>
<td>C-3 Single</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-1 Single</td>
<td>C-3 Single</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-2 Single</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-3 Single</td>
<td>No coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As shown in the chart above, your coverage will be downgraded to the next highest level your CAPP account can afford. If your CAPP account balance is insufficient to cover the quarterly cost of Plan C-3 single coverage (the lowest-cost option) and you fail to make a timely self-payment or provide proof of other medical coverage during Annual Enrollment, your coverage will lapse and you will have no coverage at all under Plan C. If this happens, in order for you to resume participation, you will be required to accumulate employer contributions in your CAPP account sufficient to cover both the initial $150 payment to the Fund (see page 14) and the monthly charge for Plan C-3 single coverage. You will be reenrolled at the start of the coverage quarter after your CAPP account reaches this level.

---

It is important that you make every effort to avoid a lapse in coverage. If your Plan C quarterly CAPP statement indicates that your account balance does not cover the full premium for coverage for the coming coverage quarter, you must make a timely self-payment to continue coverage. For those enrolled in Plan C-MRP as a standalone option, proof of other health coverage must be received each year (between mid-November and December 15).
**Participation Termination (Loss of Eligibility)**

If you have been self-paying all or part of the charge for your coverage, you lose your eligibility for continued participation in Health & Welfare Plan C when both of the following happen:

- your CAPP account balance for the next coverage quarter is zero, and
- over the preceding 24-month period, the Fund Office has not received employer contributions on your behalf equal to at least the quarterly charge for Plan C-2 single coverage.

In order to regain coverage, eligible employer contributions in your CAPP account must equal at least the cost of one month of Plan C-3 single coverage plus the initial $150 administrative fee.

If coverage ends under Plan C, you (and/or your eligible dependents) may have an opportunity to continue coverage under the federal law known as COBRA. Under COBRA, in certain circumstances, health plans are required to offer participants the opportunity to self-pay for group coverage for a limited period of time. (See page 43 for more details on COBRA.)

**Forfeited CAPP Accounts**

CAPP accounts are intended for Plan participants who are working in covered employment (as defined by Plan C) in various segments of the entertainment industry. If there has been no activity in a CAPP account for two consecutive calendar years, the balance in the account will be forfeited at the end of the second calendar year to the general assets of the Health & Welfare Fund. These forfeitures help to maintain benefits and offset administrative expenses for currently active participants. An inactive account is one that has had no Plan coverage charges, no eligible medical reimbursement claims and no new employer contributions over two consecutive calendar years. For example, an account that has had no activity in 2009 or 2010 will be closed at the end of 2010, and any account balance from activity prior to 2009 will be forfeited. In order to be eligible again once funds have been forfeited, eligible employer contributions in your CAPP account must equal at least the cost of one month of Plan C-3 single plus the initial $150 administrative fee.

---

Coverage under Health Fund Plan A will be considered activity for purposes of the forfeiture rule so long as you maintain a CAPP account balance equal to the cost of one quarter of Plan C-2 single coverage plus the $150 administrative fee.
Keep Personal Information Up to Date

It is your responsibility to make sure that the Fund has accurate information for administering your Plan C participation. Otherwise, your participation may be delayed or your coverage downgraded. For example, if the Fund Office has an incorrect or no address on file for you when you become eligible to enroll, you will not receive the necessary forms. They will be sent to you for the first day of the following quarter upon receipt of a valid address. Retroactive enrollments are not permitted. Similarly, if your coverage is downgraded or lapses due to an incorrect address on file, you will not be permitted to make any retroactive payments to reinstate your original coverage. If coverage lapses, you will need to requalify based on Plan rules. If coverage is downgraded, you will not be permitted to upgrade until Annual Enrollment unless you experience a qualifying event.

You must notify the Fund Office promptly if:

- you marry or enter into a domestic partnership
- a child is born to you, you adopt a child or acquire a stepchild or a child is placed with you for adoption
- you change your address or phone number. (This can be done online at www.iatsenbf.org.)
- you are divorced or a domestic partnership ends
- a covered dependent dies
- a child reaches the maximum age for coverage or a disabled child covered beyond age 26 marries
- you want to change your beneficiary. (This can be done online at www.iatsenbf.org.)
Changing Your Coverage

Terms You Should Know...

- **Change in family status** is an event (such as marriage, divorce or the birth of a child) that allows you to change your enrollment election soon after the event occurs.

- **Special enrollment** is a Plan provision that allows you to enroll yourself or a dependent in Plan C or upgrade to Plan C-1 or C-2 under certain circumstances, such as having a baby or losing coverage under another plan.

Generally, if you wish to change from single to family coverage, to upgrade from Plan C-3 or C-2, or to switch from Plan C-MRP to C-1, C-2 or C-3, you must wait until Annual Enrollment (mid-November to December 15). If you are already enrolled in family coverage, you may add another dependent as of the first day of the month following the Fund’s receipt of the request to add the dependent and proof of dependent status. You may downgrade your coverage as of the start of the next coverage quarter, provided that the Fund Office receives your written request by the due date for self-payments for that quarter. However, certain circumstances outlined below allow you to change (or begin) coverage at the start of any month.

**Change in Family Status and Special Enrollment Situations**

You may enroll yourself and/or your dependents in Plan C, or change your coverage option outside the Annual Enrollment period if any of the following situations apply:

- You get married, enter into a domestic partnership or have a child (by birth, adoption or placement for adoption) after you first become eligible, in which case your written request to enroll and applicable proof (such as a marriage or birth certificate) must be received by the Fund Office within 30 days of the event.

- You enrolled in Plan C-MRP as a standalone option or declined to enroll your dependent(s) because you and/or your dependent(s) were covered under another medical plan, and you (or your dependent(s)) involuntarily lose that coverage. Involuntary loss of coverage means you or your dependent(s) lose coverage under a health plan for any of the following reasons:
  - termination of employment
  - reduction in hours worked
  - your spouse dies
  - you and your spouse divorce
  - your dependent loses dependent status
  - you move out of an HMO service area, your coverage terminates and no other group coverage is available
– you or your dependent’s plan stops offering coverage to a group of similarly situated individuals
– you or your dependent incurs a claim that would meet or exceed a lifetime limit on all benefits
– you or your dependent’s employer stops contributing toward coverage
– the other coverage was COBRA continuation and you or your dependent reaches the maximum length of time for COBRA continuation
– the other plan terminates.

Loss of coverage does not include failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim) or a voluntary termination of coverage by you or your dependent. Your written request to enroll and proof of loss of coverage must be received by the Fund Office within 30 days of the loss. If you were enrolled in Plan C-MRP and have lost other coverage you must enroll in Plan C-1, C-2 or C-3 or you will be enrolled automatically in Plan C-2 single coverage. If the funds in your CAPP account are not sufficient for Plan C-2 single coverage, your coverage will lapse, and you will not be able to reenroll until the balance in your CAPP account equals the monthly charge for Plan C-3 single coverage plus the $150 administrative fee.

• You are required to provide dependent coverage through a Qualified Medical Child Support Order (QMCSO).

• You and your dependents have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. The Fund must receive your written request to enroll and proof of such loss within 60 days after the Medicaid or CHIP coverage ends.

• You (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, the Fund must receive your written request to enroll and proof of eligibility within 60 days after you (or your dependents) are determined to be eligible for such assistance.

Provided the applicable deadline is met, changes will be permitted as of the first day of the month following the Fund Office’s receipt of the written request, applicable proof of change in family status or special enrollment situation, and any required payment, as long as the change is consistent with the event. Eligibility may be terminated retroactively, or you may lose benefits if you fail to notify the Fund Office in writing of a change in family status or special enrollment event within the applicable time period described above.

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

You may be eligible to change or begin your participation in Plan C if you have a change in family status or qualify for a special enrollment.
When Coverage Ends

Terms You Should Know...

- **Certificate of Creditable Coverage** is a notice you receive when your coverage ends that indicates the period of time you were covered under the Plan. You may need the Certificate when you enroll in a new plan or apply for coverage on your own.

- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** requires that this Plan offer you and your eligible dependents the opportunity to extend health care coverage at group rates in certain instances (called qualifying events) when coverage under the Plan would otherwise end.

- **Family and Medical Leave Act (FMLA)** refers to the law that allows you to take unpaid time off for your own or a family member’s serious illness or to take care of a new baby.

- **TRICARE** is a health care program provided by the government for uniformed service members and their families.

- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)** provides rights concerning health care coverage to employees who take a military leave.

Health care coverage for you under Plan C will terminate if:

- you fail to maintain your coverage—that is, you do not pay the required self-pay portion of the charge for the coverage you elect for the applicable coverage quarter and your CAPP account balance is less than the charge for one quarter of Plan C-3 single coverage, or

- your CAPP account balance is zero and you have not had employer contributions equal to the quarterly charge for Plan C-2 single coverage made over a 24-month period (see page 35), or

- the Plan terminates.

Health care coverage for your dependents will terminate if:

- your coverage ends

- they no longer meet the definition of “dependent”

- the Plan cancels Plan C coverage for all dependents

- your coverage changes from family to single, or

- the Plan terminates.

When your coverage under the Plan would otherwise end, you may be able to continue coverage by electing COBRA coverage (see page 43). The Plan also has rules for limited extensions of coverage in special situations, which are described next.
**Family and Medical Leave.** The *Family and Medical Leave Act (FMLA)* allows you to take up to 12 weeks of unpaid leave during any 12-month period:

- due to the birth, adoption or placement of a child with you for adoption
- to provide care for a spouse, child or parent who has a serious health condition, or
- for your own serious health condition, which prevents you from performing one or more essential functions of your job.

You may be entitled to up to 26 weeks during a 12-month period to take care of a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from serious illness or injuries as a result of his or her service.

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

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

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

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

If you do not return to work after the end of your *FMLA* leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called *COBRA* (see page 43).

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

- If you are on active duty for 31 days or less, you (and eligible dependents covered under Plan C when your leave began) will continue to receive the health care coverage that you would otherwise have received under this Plan.

- If you are on active duty for more than 31 days, you can continue coverage for yourself (and eligible dependents covered under Plan C when your leave began) for up to 24 months by paying 102% of the cost of coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described next).

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

If you are called to active duty, you must notify the Fund Office in writing as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Plan on the day your leave started. Unlike COBRA coverage, if you do not elect USERRA for your dependents, they cannot elect it separately.
When you are discharged (not less than honorably) from the uniformed services, your full eligibility will be reinstated on the day you return to work with an employer, provided that you return to employment within:

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

If your CAPP account is not sufficient to cover the cost of your coverage when you return to work, you will be required to self-pay the difference in order to have immediate coverage.

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

If a Participant Dies

If a participant enrolled in Plan C-MRP dies, his or her covered spouse or domestic partner and dependent children may use any balance remaining in the CAPP account for the deceased participant’s final medical expenses as well as for reimbursement of medical expenses of any dependents enrolled in Plan C-MRP before the participant’s death.

If the participant was enrolled for single coverage in Plan C-1, C-2 or C-3 and had excess funds at the time of death, those funds will remain available for reimbursement of the participant’s unreimbursed medical expenses. If a participant was enrolled in single coverage but had enrolled dependents for medical reimbursement benefits, such enrolled dependents may continue to submit claims for reimbursement until the “excess funds” as of the participant’s death are depleted.

If the participant was enrolled for family coverage in Plan C-1, C-2, or C-3 at the time of death, any dependents enrolled as of the participant’s death may continue in coverage until the participant’s CAPP account balance is zero. When the balance is less than the cost of the full quarter of coverage, the dependents may self-pay for a final quarter of coverage. Once the participant’s account balance is zero, any dependents enrolled as of the participant’s death may be able to elect to continue coverage only by electing COBRA coverage (see page 43).
Continuation of Health Care Coverage under COBRA

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

Each qualified beneficiary has a separate right to elect continuation coverage. For example, an employee’s spouse may elect continuation coverage even if the employee does not. A parent may elect to continue coverage on behalf of any dependent child, and continuation coverage may be elected for any number of dependent children who are qualified beneficiaries. The employee or the employee’s spouse may elect continuation coverage on behalf of all qualified beneficiaries.

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

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

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

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

Proof of good health is NOT required for COBRA coverage.

Newborn Children. If you have a newborn child, adopt a child or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child’s birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.
Multiple Qualifying Events. If your covered dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event. For example, if your employment ends, you and your covered dependents may be eligible for 18 months of continued coverage. If you die (a second qualifying event) during this 18-month period, your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination of employment).

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

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

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

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

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

The notice of COBRA eligibility must include the following:

- your name
- the names of your dependents
- your Social Security number and the Social Security numbers of your dependents
- your address
- the nature and date of the occurrence you are reporting along with proof of the event
- if the event is a divorce, a copy of the divorce decree
- if you are requesting a disability extension, the name of the disabled person and a copy of the disability determination letter from the Social Security Administration
- if you are reporting a second qualifying event, the name of the qualified beneficiary(ies) and the date and proof of the second qualifying event (for example, a copy of a divorce decree).
The Fund Office must notify you and/or your covered dependents of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. Full details of COBRA coverage will be furnished. You will then have 60 days to respond if you want to continue coverage—measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you.

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

- You can make your first payment when you file your COBRA election form, that is, within 60 days after the date your Plan coverage would otherwise end. In no event, however, may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended (and COBRA coverage began) through the current month.

- All subsequent payments will be due on the first day of each month for that month’s coverage (for example, June 1 for June coverage). Keep in mind that although the Fund Office sends monthly reminders that payment for COBRA coverage is due, it is your responsibility to see that your payment is at the Fund Office by the due date, whether or not you receive such reminder from the Fund Office.

- There is a 30-day grace period for all subsequent payments. (For example, the grace period for payment for June ends on June 30.) However, if you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Fund Office receives your payment for the month.

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

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

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

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

Certificate of Creditable Coverage

When your coverage under Plan C ends, you and/or your dependents are entitled by law to receive, and will receive, a Certificate of Creditable Coverage. A Certificate of Creditable Coverage indicates the period of time you and/or your dependents were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Plan ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.
The Certificate of Creditable Coverage will be provided to you (and any eligible dependents) when coverage under Plan C terminates, whether or not you or your dependents are entitled to COBRA. If coverage is continued under COBRA, you (and any eligible dependents) will receive another Certificate of Creditable Coverage when COBRA coverage ends. In addition, you (and your eligible dependents) can request the Certificate at any time within two years after coverage under Plan C ended or COBRA coverage ended, whichever is later.

You should retain your Certificate of Creditable Coverage as proof of prior coverage for your new health plan. For further information or to request a Certificate, call the Fund Office at 1-212-580-9092 in New York or 1-800-456-FUND (3863) outside New York, or write to:

Fund Administrator
IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204

Conversion Privilege
When your Plan coverage ends, including COBRA coverage, you and/or your covered dependents may be entitled to convert your medical coverage to individual contracts with the carrier that provided your benefits through the Fund. You generally have a limited number of days to exercise this right. For more information, call the carrier that provides those benefits. Note that you will not be able to convert your dental, prescription drug or vision coverage.
Hospital and Health Benefits

Terms You Should Know...

• **360° Health** is a program that provides you with personalized support through online health and wellness resources, discounts on health-related products and services and alternative therapies.

• **Annual maximum** is the maximum amount the Plan will pay for covered expenses in one calendar year.

• **Annual out-of-pocket coinsurance maximum** is the most you will have to pay in out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the Plan pays 100% of the maximum allowed amount for covered expenses for the remainder of that calendar year. Deductibles, copays, coinsurance for behavioral health care expenses and any amount above the out-of-network maximum allowed amount do not count toward the annual out-of-pocket coinsurance maximum.

• **Case Management** refers to assistance and support available when you or a member of your family faces a chronic or catastrophic illness or injury.

• **Coinsurance** is the percentage of a covered medical expense you pay.

• **Concurrent** refers to a claim or review during treatment.

• **Copay** is the fee you pay for office visits and certain covered services when you use in-network providers.

• **Covered services** are services for which the Plan pays benefits. Certain frequency or other limitations may apply.

• **Deductible** is the dollar amount you must pay each calendar year before the Plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, Plan C-1 and Plan C-2 will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. (Plan C-3 does not cover out-of-network services.)

• **Hospital/facility** means, for purposes of certifying inpatient services under the Empire portion of the Plan, a hospital or facility that is a fully licensed acute-care general facility and meets certain requirements. See page 151 for a complete description.
Terms You Should Know...(continued)

- **In-network benefits** are benefits for *covered services* delivered by *in-network providers*, suppliers, hospitals and other health care facilities. Services provided must fall within the scope of their individual professional licenses.

- **In-network provider/supplier/hospital/facility** is a doctor or other professional *provider*, durable medical equipment, home health care or home infusion supplier, hospital or other *facility* that:
  - is in Empire’s network
  - is in the network of another BlueCross and/or BlueShield plan, or
  - has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a network.

- **Maximum allowed amount** is the maximum amount the Plan reimburses for services and supplies. *In-network providers* have agreed to accept the *maximum allowed amount* as payment in full for services. *Out-of-network providers* may bill you for amounts above the *maximum allowed amount* and you will be responsible for paying any amount charged above the *maximum allowed amount*. For more detail on the *maximum allowed amount* see the section “How Much You Will Pay—Maximum Allowed Amount” on page 57.

- **Medically necessary** means services, supplies or equipment provided by a *hospital* or other *provider* of health services that are:
  - consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury
  - in accordance with standards of good medical practice
  - not solely for the convenience of the patient, the family or the *provider*
  - not primarily custodial, and
  - the most appropriate level of service that can be safely provided to the patient.

  The fact that an *in-network provider* may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it *medically necessary*.

- **Out-of-network benefits** refer to benefits for *covered services* provided by *out-of-network providers* and suppliers. *Out-of-network benefits* are generally subject to a *deductible* and *coinsurance*, which means higher out-of-pocket costs for participants.

- **Out-of-network provider/supplier/hospital/facility** is a doctor or other professional *provider*, durable medical equipment, home health care or home infusion supplier, *hospital* or other *facility* that:
  - is not in Empire’s network
  - is not in the network of another BlueCross and/or BlueShield plan, and
  - does not have a negotiated rate with another BlueCross and/or BlueShield plan.
Terms You Should Know...(continued)

- **Precertified services** are services that must be coordinated and approved by Empire’s Medical Management or Behavioral Healthcare Management Programs to be covered by the Plan. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

- **Provider** means a hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional health care practitioner under the Empire portion of the Plan. Empire will pay benefits only for covered services within the scope of the practitioner’s license. For behavioral health care purposes, “provider” includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post licensure supervised experience in psychotherapy. For maternity care purposes, “provider” includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

- **Retrospective review** is one that is conducted after you receive medical services.

- **Same-day surgery** means same-day, ambulatory or outpatient surgery that does not require an overnight stay in a hospital.

- **Urgent precertification** is one associated with medical circumstances that require a quick decision.

Your health and hospital benefits under Plan C depend on the medical option you select. Empire BlueCross BlueShield administers coverage under Plan C-1, C-2 and C-3. Each of the three options provides a comprehensive package of hospital and health care benefits. Plan C-1 and C-2 are preferred provider organizations (PPOs), which means they offer you a choice of using an in-network or out-of-network provider each time you or a covered dependent needs medical care. You are covered for medically necessary services no matter which you choose. Plan C-3 provides coverage through an exclusive provider organization (EPO), which means benefits are paid only if you use in-network doctors and hospitals.

Both the PPOs and the EPO offer a network of health care providers available to you through Empire. Health care providers include doctors, hospitals, laboratories and other medical facilities that provide health care services. Some health care providers contract with health plans like Empire to provide services to members as part of the plan’s “network.”
The advantages of using Empire’s network:
• a comprehensive Web site, www.empireblue.com, that offers access to personalized, secure information
• providers that are continuously reviewed for Empire’s high standards of quality
• minimal out-of-pocket costs for preventive care, behavioral health care and a wide variety of hospital and medical services when you stay in-network
• easy to use—no claim forms to file when you stay in-network
• coverage for you and your family when traveling or living outside of Empire’s service area

Managing Your Health Care Online

Go to www.empireblue.com where you can securely manage your health plan 24 hours a day, seven days a week. Here is what you can do:
• check status of claims
• search for doctors and specialists
• update your member profile
• get health information and tools with My Health powered by WebMD
• print plan documents
• receive information through your personal “Message Center.”

What You Need To Do. All members of your family 18 or older must register separately:
• Go to www.empireblue.com.
• Click on the Member tab and choose “Register.”
• Follow the simple registration instructions.

How to Reach Empire. You can use the Click-to-Talk feature to contact Empire three different ways:
• E-mail: You can e-mail Empire with a question 24 hours a day, seven days a week. A customer service representative will e-mail an answer back to you through your Message Center.
• Collaboration: An Empire representative will call you while you are online and navigate the site with you. The representative can even take control of your mouse, making it easier to answer your questions.
• Call Back: You can request that a representative contact you with assistance.
Get Personalized Information. After you register, click on My Health from your secure homepage for the following features:

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

Your Identification Card

When you enroll in Plan C-1, C-2 or C-3, you will receive an identification card from Empire that you can use for all your Empire health insurance services. Always carry it and show it each time you receive health care services. Every covered member of your family will get his or her own card. The information on your card includes your name, identification number and various copay amounts.

Plan Basics

The key to using your Plan is understanding how benefits are paid.

- If you are enrolled in Plan C-1 or C-2, start by choosing in-network or out-of-network services any time you need health care. Your choice determines the level of benefits you will receive.
- If you are enrolled in Plan C-3, to receive benefits you must use a provider in the Empire network or one covered through the BlueCard® PPO Program (see page 55). There are no out-of-network benefits under this Plan.

You can view and print up-to-date information about your Plan or request that information be mailed to you by visiting www.empireblue.com.
Use Your Plan to Your Best Advantage. Knowing how to use your Plan to your best advantage will help ensure that you receive high-quality health care—with maximum benefits. Here are three ways to get the most from your coverage.

- Be sure you know what is covered. That way, you and your doctor are better able to make decisions about your health care. Empire will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the Plan applies to certain types of care.

- Remember to precertify hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied. See page 86 for more information on precertification requirements.

- Ask questions about your health care options and coverage. To find answers, you can:
  - read this booklet
  - call Empire’s Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply
  - call 24/7 NurseLine and AudioHealth Library — available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss health care options and more.

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

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

- **Choice.** You can choose any in-network provider from a large network of doctors and hospitals.

- **Freedom.** You do not need a referral to see a specialist, so you direct your care.

- **Low cost.** Benefits are paid after a copay or deductible and coinsurance payment for office visits and many other services.
• **Broad coverage.** Benefits are available for a broad range of health care services, including visits to specialists, physical therapy and home health care.

• **Convenience.** Usually, there are no claim forms to file.

---

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

---

**Out-of-Network Services.** Out-of-network services are health care services provided by a licensed provider outside Empire’s PPO network or the BlueCard PPO network of other BlueCross and/or BlueShield plans. If you are enrolled in Plan C-1 or C-2, you can choose *in-network* or *out-of-network* for most services. However, some services are only available *in-network*. When you use out-of-network services, you will:

- pay an annual deductible and coinsurance, plus any amount above the *maximum allowed amount* (the maximum the Plan will pay for a covered service). If you use a BlueCard provider, you will pay only the lower of billed charges or a negotiated rate and your participant liability.

- usually have to pay the *provider* when you receive care

- need to file a claim to be reimbursed by Empire.

Here is an example of how costs compare for *in-network* and *out-of-network* care under Plan C-1.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s charge</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Maximum allowed amount</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>Plan pays provider</td>
<td>$380</td>
<td>$300 (75% of maximum allowed amount)</td>
</tr>
<tr>
<td>You pay provider</td>
<td>$20 copay</td>
<td>$200 (25% of maximum allowed amount plus the $100 above the maximum); assumes you have satisfied the deductible</td>
</tr>
</tbody>
</table>
Here is an example of how costs compare for in-network and out-of-network care under Plan C-2.

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider’s charge</strong></td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Maximum allowed amount</strong></td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Plan pays provider</strong></td>
<td>$375 or $320 (80% of maximum allowed amount), depending on the type of service</td>
<td>$240 (60% of maximum allowed amount)</td>
</tr>
<tr>
<td><strong>You pay provider</strong></td>
<td>$25 copay or $80 (20% of maximum allowed amount), depending on the type of service</td>
<td>$260 (40% of maximum allowed amount plus the $100 above the maximum allowed amount; assumes you have satisfied the deductible)</td>
</tr>
</tbody>
</table>

Remember, Plan C-3 pays benefits only for in-network care.

**How to Find an In-Network Provider**

If you live in or around eastern New York State, you can use any provider in Empire’s local network. In addition, regardless of where you live in the U.S., you can use any provider that is part of the BlueCard® PPO Program. The BlueCard PPO is a national PPO that links BlueCross and/or BlueShield PPO providers and local BlueCross and BlueShield plans across the country. When you obtain medically necessary covered health care services from providers participating in the BlueCard PPO Program, you receive the same benefits and the same in-network coverage across the country. The suitcase logo on your ID card indicates that you are a member of the BlueCard PPO Program. BlueCard PPO providers submit the claims, and you are responsible only for the applicable in-network copay under the Plan.

To find an in-network provider near you, log on to www.empireblue.com and click on “Find a Doctor.” You will find options for locating a doctor in Empire’s local area and across the country. If you live in one of the counties listed, follow the instructions for finding a local area doctor. Otherwise, follow the instructions for finding a provider in the BlueCard PPO Program. Either way, you will have the same coverage and benefits.

You can call 1-800-810-BLUE (2583) to locate in-network providers.
The BlueCard Program. The BlueCard Program is separate from the BlueCard PPO Program and is available only if you need emergency care. BlueCard Program providers, as opposed to BlueCard PPO providers, are considered out-of-network providers, except for emergency services. The BlueCard Program helps reduce your costs when you obtain emergency care from a provider who participates with another BlueCross and/or BlueShield Plan ("local Blue Plan") but is not part of the Bluecard PPO. Just show your Empire ID card to a participating provider and comply with the other terms in your Contract or Certificate of Coverage when receiving these services. For more information about the BlueCard Program, call Empire’s Member Services at 1-800-553-9603.

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

The BlueCard® Worldwide Program (outside U.S.). BlueCard Worldwide provides hospital and professional coverage through an international network of health care providers. With this program, you are assured of receiving care from licensed health care professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here’s how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct Access Number.

- Show your Empire ID card at the hospital. If you are admitted, you will have to pay only for expenses not covered by your contract, such as copays, coinsurance, deductibles and personal items. You are required to call Empire within 24 hours.

- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the health care provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any copay and amount above the maximum allowed amount.
How Much You Will Pay—Maximum Allowed Amount

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

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

You will be required to pay a portion of the maximum allowed amount if you have not met your deductible, or have a copay or coinsurance. (See the Plan Highlights beginning on page 1 for a description of applicable copays and coinsurance.)

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

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

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

In-Network and Out-of-Network Services

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

In-network services. For in-network covered services, the maximum allowed amount is the rate the provider has agreed with Empire to accept as reimbursement. Because in-network providers have agreed to accept the maximum allowed amount as payment in full for that service, you will not have to pay any amount above the maximum allowed amount. However, you may have to pay all or a portion of the maximum allowed amount for a service or item if you have not met your deductible or have a copay or coinsurance.
Out-of-network services. For out-of-network covered services, the maximum allowed amount will be based on Empire’s out-of-network provider fee schedule/rate or the out-of-network provider’s charge, whichever is less. The Fund’s payment obligation will not exceed actual billed charges.

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

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

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

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

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

However, in all of these situations you will also have to pay any amount charged in excess of the maximum allowed amount.
Emergency care: If you obtain covered services for emergency care, as defined on page 65, even if you are unable to contact Empire before the services are rendered, Empire may authorize reimbursement to you based on the in-network cost share (deductible, copay and/or coinsurance) but only up to the maximum allowed amount. However, you will still have to pay any amount billed by the provider above the maximum allowed amount. See the examples below as to what you would have to pay in such a situation.

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

Example: Plan C-2 has coinsurance of 20% for in-network hospital services, and 40% out-of-network and an out-of-network deductible. You undergo a surgical procedure in an in-network hospital. The hospital has contracted with an out-of-network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

• The out-of-network anesthesiologist’s charge for the service is $1,200. The maximum allowed amount for the anesthesiology service is $950; your coinsurance responsibility is 20% of $950, or $190; the Plan pays 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1,200 and $950. Your total out-of-pocket responsibility would be $440—$190 (20% coinsurance responsibility) plus $250 (the difference between the maximum allowed amount and the amount charged).

• You choose an in-network surgeon. The charge is $2,500. The maximum allowed amount for the surgery is $1,500; your coinsurance when an in-network surgeon is used is 20% of $1,500, or $300. The Plan pays 80% of $1,500, or $1,200. The in-network surgeon must accept the total of $1,500 (from you and the Plan) as payment in full. Your total out-of-pocket responsibility would be $300.

• You choose an out-of-network surgeon. The out-of-network surgeon’s charge for the service is $2,500. The maximum allowed amount for the surgery service is $1,500; your coinsurance for the out-of-network surgeon is 40% of $1,500, or $600 after the out-of-network deductible has been met. The Plan pays 60% of $1,500, or $900. In addition, the out-of-network surgeon could bill you the difference between $2,500 and $1,500, or $1,000, so your total out-of-pocket charge would be $1,600 (40% coinsurance plus the amount over the maximum allowed amount, plus any remaining deductible).
No in-network provider is available: In some circumstances, when there is no in-network provider available for a covered service, the Plan will reimburse you based on the applicable in-network cost sharing amount (deductible, copay or coinsurance) up to the maximum allowed amount even if you have to use an out-of-network provider. However, you will still have to pay the entire amount charged above the maximum allowed amount. You must contact Empire in advance of obtaining the covered service to obtain approval for this benefit. Please contact Customer Service for information or to request the required precertification.

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

• Plan C-2 has a 40% coinsurance for out-of-network providers and a $25 copay for in-network providers for a specialist office visit. The out-of-network provider’s charge for this service is $500. The maximum allowed amount is $200.

• Because Empire authorized the in-network cost share amount to apply in this situation, you will be responsible only for the in-network copayment of $25 and the Plan will be responsible for the remaining $175 of the $200 maximum allowed amount.

• Because the out-of-network provider’s charge for this service is $500, you may receive a bill from the out-of-network provider for the difference between the $500 charge and the maximum allowed amount of $200. Combined with your in-network copay of $25, your total out-of-pocket expense would be $325.

What Is Covered

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

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

Each of these is described in the sections that follow.
Doctor’s Services

Whether you are enrolled in Plan C-1, C-2 or C-3, the same doctor’s services are covered. The difference among the Plans is that each Plan pays a different level of benefits, and Plan C-3 pays benefits only for in-network providers and services. (See Plan Highlights on pages 1-8.)

Preventive Care. Covered preventive care services include:

- annual physical exam—one per calendar year; in-network only

- diagnostic screening tests
  - cholesterol—one every two years (except for triglyceride testing)
  - diabetes—if pregnant or considering pregnancy
  - colorectal cancer—age 40 or over, one fecal occult blood test per year and one sigmoidoscopy every two years
  - routine Prostate Specific Antigen (PSA) in asymptomatic males—over age 50, one per year; age 40 through 49 and risk factors exist, one per year; if prior history of prostate cancer, PSA at any age
  - diagnostic PSA—one per year

- well woman care
  - office visits to a gynecologist/obstetrician
  - Pap smears
  - bone density testing and treatment—age 52 to age 65, one baseline; age 65 and older, one every two years (if baseline before age 65 does not indicate osteoporosis); under age 65, one every two years (if baseline before age 65 indicates osteoporosis). Additional testing may be covered for an individual who does not meet these age requirements but meets Empire’s standards for coverage, which include the criteria for coverage under Medicare and the criteria of the National Institutes of Health for the Detection of Osteoporosis, and has one or more of the following factors: (1) Previously diagnosed with or having a family history of osteoporosis, (2) Symptoms or conditions indicative of the presence or significant risk of osteoporosis, (3) Prescribed drug regimen posing a significant risk of osteoporosis, (4) Lifestyle factors to such a degree posing a significant risk of osteoporosis, or (5) Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.
  - mammogram (based on age and medical history)—age 35 through 39, one baseline; age 40 and older, one per year
• well child care (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics)

  – in-hospital visits—for newborn, two in-hospital exams at birth following vaginal delivery or four in-hospital exams at birth following c-section delivery

  – office visits—from birth to first birthday, seven visits; age 1 through 4, seven visits; age 5 through 11, seven visits; age 12 through 17, six visits; age 18 to 19th birthday, two visits

  – lab tests

  – immunizations for DPT (diphtheria, pertussis and tetanus), polio, MMR (measles, mumps and rubella), varicella (chicken pox), hepatitis B hemophilus, tetanus-diphtheria, pneumococcal, meningococcal tetramune

Preventive care that meets certain government standards under the Affordable Care Act will be covered in full by the Fund if provided in-network. Not everything on the above list may be eligible to be paid in full. Please contact Empire at 1-800-553-9603 for more information as to which preventive services will be covered in full.

**Other Home, Office/Outpatient Care.** Other covered doctor’s services include:

• home office visits

• specialist visits

• second or third surgical opinion

• diagnostic procedures
  – x-rays and other imaging
  – radium and radionuclide therapy
  – MRIs and MRAs—precertification required

• nuclear cardiology services

• PET/CAT scans

• laboratory tests

• diabetes education and management

• allergy care
  – office visits
  – testing
  – treatment
• surgery—precertification required
• presurgical testing
• anesthesia
• chemotherapy, radiation
• kidney dialysis
• second or third medical opinion for cancer diagnosis
• cardiac rehabilitation
• consultation requested by the attending physician for advice on an illness or injury
• diabetes supplies prescribed by an authorized provider
  – blood glucose monitors, including monitors for the legally blind
  – testing strips
  – insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, insulin infusion devices
  – oral agents for controlling blood sugar
  – other equipment and supplies required by the New York State Health Department
  – data management systems
• diabetes self-management education and diet information, including:
  – education by a physician, certified nurse practitioner or member of their staff at the time of diagnosis, when the patient’s condition changes significantly, when medically necessary
  – education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  – home visits for education when medically necessary
• diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
• medically necessary hearing examinations
• foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
• chiropractic care—your provider must call Empire’s Medical Management Program to determine medical necessity of services after the fifth visit
Be sure to ask about a second opinion any time that you are unsure about surgery or a cancer diagnosis. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the *in-network* level, even if you use an *out-of-network* specialist, as long as your *in-network* doctor provides a written referral to an *out-of-network* specialist. If you visit an *out-of-network* specialist without a written referral, you must pay the *out-of-network* deductible and *coinsurance*.

**What Is Not Covered.** Medical services that are not covered include but are not limited to:

- screening tests done at your place of work at no cost to you
- free screening services offered by a government health department
- tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
- orthotics for treatment of routine foot care
- routine vision care
- routine hearing exams
- hearing aids and the examination for their fitting
- services such as laboratory, x-ray and imaging and pharmacy services as required by law from a *facility* in which the referring physician or his/her immediate family member has a financial interest or relationship
- services given by an unlicensed *provider* or performed outside the scope of the *provider’s* license.
Emergency Care

Emergency care refers to services that are provided in a hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- place the patient’s health in serious jeopardy
- cause serious problems with the patient’s body functions, organs or parts
- cause serious disfigurement
- in the case of behavioral health, place the patient or others in serious jeopardy

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

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire’s network or the PPO network of another BlueCross and/or BlueShield plan. You pay only a copay for a visit to an emergency room. This copay is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor’s office, you pay the same copay as for an office visit. Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. An in-network provider must provide all follow-up care in order to receive maximum benefits.

You will need to show your Empire BlueCross BlueShield ID card when you arrive at the emergency room.

If you are admitted to the hospital, you or someone on your behalf must call Empire’s Medical Management Program before services are rendered or within 48 hours after you are admitted to or treated at the hospital. If you do not obtain authorization from Empire within the required time, a penalty of 50% of benefits will apply.
Whether you are enrolled in Plan C-1, C-2 or C-3, the same emergency services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Here is a list of covered emergency services under Plans C-1, C-2 and C-3:

- emergency room—copay waived if admitted to the same hospital within 24 hours; certification required within 48 hours of an emergency hospital admission
- physician’s office
- emergency air ambulance to nearest acute care hospital for emergency inpatient admissions
- emergency land ambulance (local professional ground ambulance to nearest hospital)

**Emergency Air Ambulance.** The Plan provides in-network coverage for air ambulance services when needed to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care, subject to cost-sharing obligations, when the following conditions are met:

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

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

**Emergency Land Ambulance.** For a true emergency, the Plan covers land ambulance transportation to the nearest acute care hospital in connection with emergency room care or emergency inpatient admission, provided by an ambulance service. Benefits are not available for transfers of covered members between health care facilities. Note: State law prohibits land ambulance providers in New York State from balance billing beyond reasonable and customary amounts.
If You Have an Emergency Outside Empire’s Service Area. If you have an emergency while outside Empire’s service area anywhere in the United States, follow the same steps described previously. If the hospital participates with another BlueCross and/or BlueShield plan in the BlueCard® PPO program, your claim will be processed by the local plan. Be sure to show your Empire ID card at the emergency room, and if you are admitted, notify Empire’s Medical Management Program within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim. Empire’s service area consists of the following 34 New York State counties: Albany, Bronx, Broome, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

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

What Is Not Covered. Emergency services that are not covered include but are not limited to:

• use of the emergency room to treat routine ailments because you have no regular physician or because it is late at night (and the need for treatment is not sudden and serious)

• ambulette.

Maternity Care

Under Empire’s Maternity Care Program, specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby’s birth. While most pregnancies end successfully with a healthy mother and baby, Empire’s Maternity Care Program is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies and can also provide home health care referrals and health education counseling.

Call Empire as soon as you know that you are pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in the Maternity Care Program. Call 1-800-845-4742 and listen for the prompt that says, “precertify.” You will be transferred to the Maternity Care Program.
Whether you are enrolled in Plan C-1, C-2 or C-3, the same maternity care services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Here is a list of covered maternity care services under Plans C-1, C-2 and C-3:

- prenatal and postnatal care (in doctor’s office)—precertification required
- lab tests, sonograms and other diagnostic procedures
- routine newborn nursery care
- obstetrical care in hospital—precertification required
- obstetrical care in birthing center—in-network only; precertification required
- one home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. (See page 69 for more information.) The mother must request the visit from the hospital or a home health care agency within this timeframe. (Precertification is not required.) The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- services of a certified nurse-midwife affiliated with a licensed facility. The services must be provided under the direction of a physician.
- parent education and assistance and training in breast or bottle feeding, if available
- circumcision of newborn males
- special care for the baby if the baby stays in the hospital longer than the mother—precertification required for hospital stay
- semi-private room

To obtain coverage for your newborn, contact the Fund Office in writing and provide the child’s birth certificate within 30 days of the birth. Your newborn will be covered from the date of birth provided the Fund receives such request and birth certificate within the 30 days. If you are not already enrolled in family coverage, you will also need to enroll and pay for family coverage as of the first day of the month following the child’s birth to ensure the baby’s coverage continues beyond 30 days.
**Minimum Maternity Stay.** Under the federal law called the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), a plan may not restrict a mother’s or a newborn child’s benefits for a hospital stay to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, this law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours (as applicable). In any case, a plan may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**What Is Not Covered.** Maternity care services that are not covered include but are not limited to:

- days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits)
- services that are not medically necessary
- private room
- out-of-network birthing center facilities
- private duty nursing.

*Use an in-network obstetrician/gynecologist to receive the lowest-cost maternity care.*

**Infertility Treatment**

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations. Whether you are enrolled in Plan C-1, C-2 or C-3, the same infertility treatment services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Here is a list of covered infertility treatment services under Plans C-1, C-2 and C-3:

- medical and surgical procedures, such as artificial insemination, intrauterine insemination and dilation and curettage (D&C), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility
- services in relation to diagnostic tests and procedures necessary to determine infertility, or in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:
  - hysterosalpingogram
  - hysteroscopy
  - endometrial biopsy
– laparoscopy
– sono-hysterogram
– post coital tests
– testis biopsy
– semen analysis
– blood tests
– ultrasound, and
– other medically necessary diagnostic tests and procedures, unless excluded by law

• prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services, subject to all the conditions, exclusions, limitations and requirements that apply to all other prescription drugs under this Plan.

What Is Not Covered. Infertility treatment services that are not covered include but are not limited to:

• in-vitro fertilization
• gamete intra fallopian transfer (GIFT)
• zygote intra fallopian transfer (ZIFT)
• reversal of elective sterilizations, including vasectomies and tubal ligations
• sex-change procedures
• cloning
• medical or surgical services or procedures that are experimental
• a service to diagnose or treat infertility if, in the sole judgment of Empire, it was not medically necessary.
If you convert to an individual policy after your coverage under Plan C ends, your new policy may not include infertility benefits.

Hospital Services

The Plan covers medically necessary care when you stay at a hospital for surgery or treatment of illness or injury. The medical necessity and length of any hospital stay are subject to Empire’s Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the Medical Management section (which begins on page 86) for additional information.

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

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

You MUST call Empire’s Medical Management Program at 1-800-982-8089 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Medical Management within 48 hours. Otherwise, your benefits may be reduced by 50% up to $5,000 for each hospital admission or surgery that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

Whether you are enrolled in Plan C-1, C-2 or C-3, the same hospital services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.)
Covered Inpatient and Outpatient Care. Here is a list of hospital services covered and limitations under Plans C-1, C-2 and C-3 for both inpatient and outpatient (same-day) care:

- diagnostic x-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- anesthesiologist, including one consultation before surgery and services during and after surgery
- blood and blood derivatives for emergency care, same-day surgery or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, when preapproved by Empire’s Medical Management Program (your provider must call to precertify these services). You must call to precertify out-of-network MRIs/MRAs.
- PET/CAT scans and nuclear cardiology services.

Covered Inpatient Care. Here is a list of additional hospital services under Plans C-1, C-2 and C-3 for inpatient care:

- semi-private room and board when the patient is under the care of a physician, and a hospital stay is medically necessary. (Coverage is for unlimited days, subject to Empire’s Medical Management Program review, unless otherwise specified.)
- operating and recovery rooms
- special diet and nutritional services while in the hospital
- cardiac care unit
- services of a licensed physician or surgeon employed by the hospital
- care related to surgery
- breast cancer surgery (lumpectomy, mastectomy), including:
  - reconstruction following surgery
  - surgery on the other breast to produce a symmetrical appearance
  - prostheses
  - treatment of physical complications at any stage of a mastectomy, including lymphedemas
• use of cardiographic equipment
• drugs, dressings and other medically necessary supplies
• social, psychological and pastoral services
• reconstructive surgery associated with injuries unrelated to cosmetic surgery
• reconstructive surgery for a functional defect which is present from birth
• physical, occupational, speech and vision therapy including facilities, services, supplies and equipment
• facilities, services, supplies and equipment related to medically necessary medical care.

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

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

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

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.
What Is Not Covered. Inpatient services that are not covered include but are not limited to:

- private duty nursing
- private room. If you use a private room, you will pay the difference between its cost and the hospital’s average charge for a semi-private room. The additional cost cannot be applied to your deductible or coinsurance maximum.
- diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
- services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums or infirmaries at schools, colleges or camps
- any part of a hospital stay that is primarily custodial
- elective cosmetic surgery or any related complications
- hospital services received in clinic settings that do not meet Empire’s definition of a hospital or other covered facility as defined in the glossary beginning on page 148.

Outpatient Care. Here is a list of additional covered hospital services under Plans C-1, C-2 and C-3 for outpatient (same-day) care:

- same-day and hospital outpatient surgical facilities
- surgeons
- surgical assistant if none is available in the hospital or facility where the surgery is performed, and the surgical assistant is not a hospital employee
- chemotherapy and radiation therapy, including medications in a hospital outpatient department, doctor’s office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis). Any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered.
  - in a hospital-based or freestanding facility as defined in the glossary beginning on page 148.
**What Is Not Covered.** Outpatient services that are not covered include but are not limited to:

- **same-day surgery not precertified as medically necessary** by Empire’s Medical Management Program
- **routine medical care** including but not limited to inoculation or vaccination and drug administration or injection, excluding chemotherapy
- **collection or storage** of your own blood, blood products, semen or bone marrow.

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

**Durable Medical Equipment and Supplies**

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

---

**Network suppliers must precertify** the rental or purchase of *medically necessary* prosthetics, orthotics and durable medical equipment by calling Empire’s Medical Management Program at 1-800-982-8089. If you use a supplier outside Empire’s operating area through the BlueCard PPO Program, you are responsible for the precertification.

Disposable medical supplies, such as syringes, are covered up to the *maximum allowed amount* whether you obtain them in network or out of network. Enteral formulas or other dietary supplements for certain severe conditions are also covered in and out of network.
Whether you are enrolled in Plan C-1, C-2 or C-3, the same durable medical equipment and supplies are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Here is a list of covered durable medical equipment and supplies under Plans C-1, C-2 and C-3:

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

What Is Not Covered. Equipment that is not covered includes but is not limited to:

- air conditioners or purifiers
- humidifiers or dehumidifiers
- exercise equipment
- swimming pools
- false teeth
- hearing aids.
Skilled Nursing and Hospice Care

You are covered under Plan C for inpatient care in a skilled nursing facility or hospice. Benefits are available for in-network facilities only.

In order to receive maximum benefits, call 1-800-982-8089 to precertify skilled nursing care with Empire’s Medical Management Program. The Program will help direct you to a skilled nursing facility that provides the appropriate care.

Whether you are enrolled in Plan C-1, C-2 or C-3, the same skilled nursing and hospice care services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.)

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

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

Prior hospitalization is not required in order to be eligible for skilled nursing care benefits.

**What Is Not Covered.** Skilled nursing facility care that primarily does any of the following is not covered:

- gives assistance with daily living activities
- is for rest or for the aged
- treats drug addiction or alcoholism
- provides convalescent care
- provides sanitarium-type care
- provides rest cures.
**Hospice Care.** Plan C covers up to 210 days of hospice care once in a covered person’s lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of an in-network hospital or at home, as long as it is provided by an in-network hospice agency. Covered hospice care services include:

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

**Home Health Care**

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network.

---

*If you are in Plan C-1 or C-2 and use an out-of-network agency, it must be certified by New York State or have comparable certification from another state.*
You are covered for up to 200 home health care visits per calendar year (combined in-network and out-of-network visits for Plan C-1 or C-2). A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.

Whether you are enrolled in Plan C-1, C-2 or C-3, the same home health care services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Here is a list of covered home health care services under Plans C-1, C-2 and C-3:

• part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
• part-time home health aide services (skilled nursing care)
• physical, speech or occupational therapy, if restorative
• medications, medical equipment and supplies prescribed by a doctor
• laboratory tests.

**What Is Not Covered.** Home health care services that are not covered include but are not limited to:

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

**Physical, Occupational, Speech and Vision Therapy**

Plan C covers up to 30 days of inpatient physical therapy and rehabilitation per calendar year (in or out of network if you are in Plan C-1 or C-2). It also covers up to 30 visits a year in your home, office or at an outpatient facility—but from in-network providers only. In addition, the Plan covers up to an additional 30 visits if medically necessary in the 12 months following a surgical procedure related to the treatment of a neurological disorder. Neurological disorders may include, but are not limited to, amyotrophic lateral sclerosis, cerebral palsy, epilepsy, Parkinson’s disease, muscular dystrophy, multiple sclerosis, spastic paraplegia, and Tourette’s syndrome.

**Call Empire’s Medical Management Program at 1-800-982-8089 to precertify all physical, occupational, and speech therapy services. This will ensure that you receive maximum benefits.**
Whether you are enrolled in Plan C-1, C-2 or C-3, the same physical therapy and rehabilitation services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.) Physical therapy, physical medicine or rehabilitation services or any combination of these are covered up to the Plan maximums if they are prescribed by a physician, designed to improve or restore physical functioning within a reasonable period of time and approved by Empire’s Medical Management Program. Outpatient care must be given at home, in a therapist’s office or in an outpatient facility by an in-network provider. Inpatient therapy must be short term.

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

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

**What Is Not Covered.** Therapy services that are not covered include but are not limited to:

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

**Behavioral Health Care**

If you are in Plan C-1 or C-2, outpatient treatment for both alcohol or substance abuse and mental health is covered both in network and out of network (up to a fixed number of visits per calendar year). However, inpatient treatment is covered in network only (up to a fixed number of days per year). If you are in Plan C-3, only in-network behavioral health care is covered (up to a fixed number of days or visits per calendar year).

Except for out-of-network outpatient visits for mental health (Plan C-1 and C-2 only) and the first 12 routine in-network outpatient visits each calendar year, all behavioral health care services must be precertified by calling Empire’s Member Services at 1-800-553-9603. A customer service representative will connect you to a care manager, who can refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.
If you do not call to precertify behavioral health care, or if you call but do not follow Empire’s recommended treatment plan, benefits may be denied or reduced as described on page 88. If you do not agree with a certification decision made, you can file an appeal. See Claims and Appeals Procedures, which begins on page 121.

When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call Empire’s Member Services at 1-800-553-9603 within 48 hours.

Whether you are enrolled in Plan C-1, C-2 or C-3, the same behavioral health services are covered. The difference among the Plans is how much you will pay out of pocket. (See Plan Highlights on pages 1-8.)

Covered Mental Health Care. You are covered for up to 40 outpatient visits (combined in and out of network for Plan C-1 or C-2) and 30 inpatient treatment days per calendar year. Covered services include:

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

What Is Not Covered. Mental health care services that are not covered include but are not limited to:

- care that is not medically necessary
- out-of-network inpatient mental health care at a facility that is not an acute care general hospital.
Covered Treatment for Alcohol or Substance Abuse. You are covered for up to 60 outpatient visits (combined in and out of network for Plan C-1 or C-2) and seven days of inpatient detoxification per calendar year. Covered services include family counseling services at an outpatient treatment facility. These can take place before the patient’s treatment begins. Any family member covered by the Plan may receive one counseling visit per day. Visits for family counseling are deducted from the 60 visits available for outpatient treatment.

For Plans C-1 and C-2, out-of-network outpatient treatment must be provided at a facility that has New York State certification from the Office of Alcoholism and Substance Abuse Services or, if outside of New York State, is approved by the Joint Commission on the Accreditation of Health Care Organizations. The program must offer services appropriate to the patient’s diagnosis.

What Is Not Covered. Alcohol and substance abuse treatment services that are not covered include but are not limited to:

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

Other Services Not Covered

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

Dental Services

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

- technology, treatments, procedures, drugs, biological products or medical devices that in Empire’s judgment are experimental or investigational, or obsolete or ineffective

- any hospitalization in connection with experimental or investigational treatments. “Experimental” or “investigative” means that for the particular diagnosis or treatment of the covered person’s condition, the treatment is not of proven benefit or not generally recognized by the medical community (as reflected in published medical literature).

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person’s condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- final market approval by the U.S. Food and Drug Administration (FDA) for the patient’s particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.

- published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes

- published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects)

- published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

However, the Plan will cover an experimental or investigational treatment approved by an External Review agent. The process for External Reviews is described on page 133 of this document.
Government Services

- services covered under government programs, except Medicaid or where otherwise noted

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

Home Care

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

Inappropriate Billing

- services usually given without charge, even if charges are billed

- services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified

Medically Unnecessary Services

- services, treatment or supplies not medically necessary in Empire’s judgment. See the glossary for more information.

Miscellaneous

- surgery and/or treatment for gender change

Prescription Drugs

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

Sterilization/Reproductive Technologies

- reversal of sterilization

- assisted reproductive technologies including but not limited to in-vitro fertilization, intracytoplasmic sperm injection and gamete and zygote intrafallopian tube transfer
Travel

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

Vision Care

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

War

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

Workers’ Compensation

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

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

Health Management

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

• Medical Management Program/Precertification

• Case Management

• 360° Health.
Precertification and Medical Management

Empire’s Medical Management Program is a service that precertifies hospital admissions and certain treatments and procedures to ensure that you receive high-quality care for the right length of time in the right setting with maximum coverage. When you call Empire’s Medical Management Program, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- learn more about your health care options
- avoid unnecessary hospitalization and the associated risks, whenever possible
- choose the most appropriate health care setting or service (e.g., hospital or same-day surgery unit)
- arrange for any required (and covered) discharge services.

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

- review planned and emergency hospital admissions
- review ongoing hospitalization
- review inpatient and same-day surgery
- review high-risk pregnancies
- review routine maternity admissions
- perform individual Case Management
- review care in a skilled nursing facility
- coordinate discharge planning.

In most situations, you or someone acting on your behalf needs to call the Medical Management Program to precertify hospital admissions and certain services. In other cases, the vendor or provider of services needs to call. This will ensure you receive maximum benefits.
The following chart shows which health care services must be **precertified** with Empire’s Medical Management Program before you receive them.

<table>
<thead>
<tr>
<th>WHEN PRECERTIFICATION ☑ IS REQUIRED</th>
<th>PLAN C-1 AND C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL HOSPITAL ADMISSIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At least two weeks prior to any planned surgery or hospital admission</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• Within 48 hours of an emergency hospital admission</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• For illness or injury to newborns</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td><strong>PREGNANCY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Within the first three months of a pregnancy</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td><strong>BEFORE YOU RECEIVE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient physical therapy</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• Same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures</td>
<td><strong>In-network and out-of-network</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• Behavioral health care*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BEFORE YOU RECOVER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occupational or speech therapy</td>
<td><strong>In-network only</strong></td>
<td><strong>You</strong></td>
</tr>
<tr>
<td>• Outpatient physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing facility care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BEFORE YOU RENT, PURCHASE OR REPLACE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prosthetics, orthotics or durable medical equipment</td>
<td>Empire network</td>
<td>Empire network</td>
</tr>
<tr>
<td></td>
<td>Network supplier</td>
<td>Empire network</td>
</tr>
<tr>
<td></td>
<td>BlueCard PPO network</td>
<td>BlueCard PPO network</td>
</tr>
<tr>
<td><strong>BEFORE YOU RECEIVE MRIs/MRAs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• It is the provider’s responsibility to call Empire for precertification of all in-network MRIs/MRAs.</td>
<td>Empire network</td>
<td>Provider</td>
</tr>
<tr>
<td>• If you are in Plan C-1 or C-2, it is your responsibility to call Empire for precertification of out-of-network MRIs/ MRAs.</td>
<td>BlueCard PPO network</td>
<td>No precertification required</td>
</tr>
<tr>
<td></td>
<td>Out-of-network</td>
<td>You</td>
</tr>
</tbody>
</table>

*Precertification is not required for out-of-network outpatient mental health visits (Plan C-1 and C-2 only) or for the first 12 routine in-network outpatient mental health visits each year.

---

**When you call the Medical Management Program to precertify services, you receive maximum benefits and helpful advice about your options. If you do not precertify when required, penalties will apply.**
If Services Are Not Precertified. If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $5,000 for each admission, treatment or procedure. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

What You Will Need When You Call. Have the following information about the patient ready when you call:

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

If a vendor or provider is required to call Empire’s Medical Management Program for precertification, be sure the vendor or provider knows about the requirement and has the Medical Management telephone number.

Initial Decisions. Empire will comply with the following timeframes in processing precertification and concurrent and retrospective requests for review of services.

- Empire will review and respond to all requests for precertification within three business days of receipt of all the necessary information. If, after 15 days of receiving the initial request, Empire does not receive enough information to make a decision, you will be notified in writing of the additional information that is needed, and you and your provider will have 45 calendar days to respond. Empire will make a decision within three business days of receipt of the requested information or, if no response is received, within three business days after the deadline for your response.

- If you request an urgent precertification, Empire will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of receipt of the request. If the request is urgent and Empire requires further information to make a decision, you will be notified within 24 hours of receipt of the request, and you and your provider will have 48 hours to respond. Empire will make a decision within 48 hours of receipt of the requested information or, if no response is received, within 48 hours after the deadline for your response.
• A **concurrent review** is one in which Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. All concurrent reviews of services will be completed within 24 hours of Empire's receipt of the request.

• A **retrospective review** is conducted after you receive medical services. Empire will complete all retrospective reviews of services already provided within 30 calendar days of receipt of the claim. If Empire does not have enough information to make a decision within 30 calendar days, you will be notified in writing of the additional information that is needed, and you and your provider will have 45 calendar days to respond. A decision will be made within 15 calendar days of Empire's receipt of the requested information or, if no response is received, within 15 calendar days after the deadline for your response.

• If Empire's Medical Management Program does not meet the above timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

**If a Request Is Denied.** All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity or because the service has been determined to be experimental or investigational, Empire’s Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See Claims and Appeals Procedures, which begins on page 121, for more information.

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

**Requesting Coverage for New Medical Technology.** Empire uses a committee composed of Empire Medical Directors (doctors and participating in-network physicians) to continuously evaluate new medical technologies that have not yet been designated as covered services. If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire’s Medical Management Program. The provider will be asked to provide:

• full supporting documentation about the new medical technology

• an explanation of how standard medical treatment has been ineffective or would be medically inappropriate

• scientific peer-reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.
Empire’s staff will evaluate the proposal in light of the rules of the Plan and Empire’s current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer-reviewed articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to the member and/or provider.

**Case Management**

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

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

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

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

**360° Health**

As a member of Plan C-1, C-2 or C-3, you have access to programs and services to help you achieve and maintain your highest potential for good health—at no additional charge. 360° Health surrounds you with personalized support by providing online health and wellness resources, discounts on health-related products and services and alternative therapies and guidance and support when you need help.
Prescription Drug Benefit

Terms You Should Know...

- **Brand-name drug** refers to a prescription drug sold under the registered or trademarked name given to it by the drug manufacturer that holds the manufacturing and marketing rights to that drug.

- **CVS Caremark Mail Service Pharmacy** is the prescription drug mail service under the Plan through which you can fill your and your enrolled dependents’ prescriptions for most maintenance and long-term drugs (those taken for more than 30 days).

- **Generic drug** refers to a lower-cost equivalent of a brand-name drug. It is approved by the U.S. Food and Drug Administration (FDA) and has the same active ingredients as its brand-name equivalent.

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

**Retail Pharmacy**

If you are enrolled in Plan C-1, C-2 or C-3, you can fill a prescription at an in-network or out-of-network retail pharmacy. You will pay less if you use an in-network pharmacy—and there will be no claim forms to file.

**Using an In-Network Pharmacy.** When you go to an in-network retail pharmacy, you need to bring your CVS Caremark ID card and your doctor’s written prescription. Your copay depends on whether you:

- are enrolled in Plan C-1, C-2 or C-3
- fill a short-term or 90-day prescription, and
- fill your prescription with a generic drug, a brand-name drug that does not have a generic equivalent or a brand-name drug that does have a generic equivalent.
No copay for certain preventive care prescriptions: Prescriptions that are considered preventive care under the Affordable Care Act will be covered in full in-network and the above copay schedule will not apply. Contact CVS Caremark for more information as to whether a particular prescription will be covered in full.

Do not forget to take your Caremark ID card with you when you go to an in-network retail pharmacy.

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

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

Mail Service Pharmacy

The CVS Caremark Mail Service Pharmacy is designed for filling prescriptions for maintenance medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes or asthma. When you fill prescriptions through the Mail Service Pharmacy, you can elect delivery either to your home or an alternate address. (See page 93 for instructions on how to fill your initial prescription and order refills through the Mail Service Pharmacy.)
If you take maintenance drugs or other long-term prescriptions, you must fill your prescription through the CVS Caremark Mail Service Pharmacy or at a local CVS pharmacy in order for benefits to be payable beyond the second fill (the initial prescription and one refill).

The Mail Service Pharmacy offers both convenience and savings. When you use the Mail Service, you pay two times the amount you would pay at a retail pharmacy and receive up to three times the amount. Your copay for a 90-day supply depends on whether you:

- are enrolled in Plan C-1, C-2 or C-3, and
- fill your prescription with a generic drug, a brand-name drug that does not have a generic equivalent or a brand-name drug that does have a generic equivalent.

<table>
<thead>
<tr>
<th></th>
<th>PLAN C-1</th>
<th>PLAN C-2</th>
<th>PLAN C-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic drug</strong></td>
<td>$12.50</td>
<td>$12.50</td>
<td>$12.50</td>
</tr>
<tr>
<td><strong>Brand-name drug without generic equivalent</strong></td>
<td>20% ($50 minimum/ $87.50 maximum)</td>
<td>20% ($87.50 minimum/ $125 maximum)</td>
<td>20% ($87.50 minimum/ $125 maximum)</td>
</tr>
<tr>
<td><strong>Brand-name drug with generic equivalent</strong></td>
<td>40% ($75 minimum/ $112.50 maximum)</td>
<td>40% ($112.50 minimum/ $150 maximum)</td>
<td>40% ($112.50 minimum/ $150 maximum)</td>
</tr>
</tbody>
</table>

**Filling Your Initial Prescription through the Mail Service Pharmacy.** If your doctor prescribes a maintenance or other long-term medication, follow these steps to fill your initial prescription through the CVS Caremark Mail Service Pharmacy:

- First, get a 90-day prescription from your doctor with up to as many as three refills (if appropriate).
- Complete the Mail Service order form, which you can fill out and print online at www.caremark.com. Simply log on and click “New Prescriptions.” (Keep in mind that an incomplete form can cause a delay in processing.)
- Mail your order form along with your prescription(s) and payment in an envelope to the CVS Caremark Mail Service Pharmacy address printed on the form. You can pay using an electronic check, Bill Me Later®, credit card, personal check or money order. You may not send cash.

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

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

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

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

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

What Is Covered

The Plan covers the following:

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

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

What Is Not Covered

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

- medications, vitamins, supplements, etc. for both adults and children that may be lawfully obtained without a prescription, except that certain over-the-counter substances will be covered in full if they are considered preventive care under the Affordable Care Act
- appliances, devices, support garments, non-medical substances
- administration charges for drugs or insulin
- experimental, investigational or unlabeled use of drugs
- unauthorized refills
• prescriptions covered without charge under federal, state or local programs, including Workers’ Compensation

• medications while confined in a rest home, nursing home, extended care facility or similar facility

• medication used for cosmetic purposes (for example, Retin-A for individuals over age 25)

• over-the-counter medicine, unless otherwise specified

• allergy serums

• anorexiants (diet aids)

• nicotine transdermal systems

• lupron

• fertility drugs (oral & injectable)

• fluoride dental products

• imitrex autoinjector & refill vials

• prescription vitamins

• diaphragms

• yohimbine

• ostomy products

• sexual dysfunction drugs

• certain restricted medications for which a diagnosis code and/or a letter of necessity was not provided.

If you need assistance, you can email CVS Caremark Customer Care at customerservice@caremark.com or call 1-800-896-1997 for general information. You can also log on to Caremark’s Web site at www.caremark.com to refill your prescriptions, check on the status of your order and obtain important medicine information.
Vision Care Benefit

Vision care benefits, provided through Davis Vision, are available under Plans C-1 and Plan C-2. Plan C-3 does not provide vision care benefits. Vision care benefits help to pay for routine eye examinations, frames and lenses for you and your covered dependents.

What Is Covered

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

To find a Davis Vision in-network provider, call 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will provide you with the names and addresses of the in-network providers nearest you. You can also search for a provider by registering at www.davisvision.com.

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

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

- plastic or glass single vision, bifocal or trifocal lenses, in any prescription range
- intermediate vision lenses
- glass grey #3 prescription lenses
- post cataract lenses
- fashion, sun or gradient tinted plastic lenses
- polycarbonate lenses for dependent children and monocular patients
- ultraviolet (UV coating)
- blended invisible bifocals
- Photogrey Extra® (sun-sensitive) glass lenses.
When you purchase lenses, you have the option of adding any of the items listed below at discounted fixed fees, as follows:

- polycarbonate lenses: $30
- scratch-resistant coating: $20
- standard ARC (anti-reflective coating): $35
- premium ARC (anti-reflective coating): $48
- polarized lenses: $75
- plastic photosensitive lenses: $65
- high-index (thinner and lighter) lenses: $55
- standard progressive addition lenses: $50
- premium progressive addition lenses: $90 (While these lenses can be worn by most people, conventional bifocals will be supplied to anyone who is unable to adapt to progressive addition lenses; the copay, however, will not be refunded.)

Davis Vision provides you and your eligible dependents with the opportunity to receive laser vision correction services at discounts of up to 25% off an in-network provider’s normal charges, or 5% off any advertised special. (Please note that some providers have flat fees equivalent to these discounts.) Be sure to check the discount available to you with the in-network provider.

Frames. You and each covered dependent are entitled to one pair of standard frames from the Davis Vision Collection every 24 months. No copay is required. Premier frames are available from the Collection for a $25 copay. Alternatively, if you choose an in-network provider’s own frame, you will receive a $45 allowance toward the cost of the frame.

All Davis Vision eyeglasses are covered by a one-year breakage warranty.
Contact Lenses. You and each covered dependent are entitled to contact lenses every 24 months. No copay is required for the following:

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

Davis Vision offers free membership to Lens 1-2-3®, a fast and convenient way to purchase replacement contact lenses by mail at significant savings. For more information, call 1-800-LENS-123 (1-800-536-7123) or visit www.Lens123.com.

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

Receiving Services from an In-Network Provider

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

If You Use an Out-of-Network Provider

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

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

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

You have 18 months from the date of service to file an out-of-network claim.
What Is Not Covered

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

• medical treatment of eye disease or injury (although this may be covered as part of your Empire BlueCross BlueShield medical benefits)

• vision therapy

• special lens designs or coatings

• replacement of lost eyewear

• non-prescription (plano) lenses

• services not performed by licensed personnel

• two pairs of eyeglasses in lieu of bifocals

• contact lenses and eyeglasses in the same benefit cycle.

Call Davis Vision at 1-800-999-5431. Representatives are available Monday through Friday, 8 am to 11 pm ET; Saturday, 9 am to 4 pm ET; and Sunday, noon to 4 pm ET. You can also register and log on to www.davisvision.com at any time to find a provider, check your eligibility or benefits and download an out-of-network claim form.
Dental benefits, provided through Delta Dental, are available under Plans C-1, C-2 and C-3. Plans C-1 and C-2 provide comprehensive dental coverage. Plan C-3, however, covers only basic preventive care. The Schedule of Dental Benefits, which begins on page 105, shows which services are covered under Plan C-3.

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

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

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

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

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

In order to qualify for reimbursement, an expense must:

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

How Much You Will Pay

As shown in the Schedule of Dental Benefits, which begins on page 105, the Fund pays a fixed allowance for each covered service. You pay for the portion of the dentist’s fee that exceeds the allowance (plus any amount over the annual maximum and the full amount for any services not covered by your Plan).

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

Example. Here is a comparison of how much you would pay a PPO dentist, a Premier dentist and an out-of-network dentist for a crown that costs $2,000 unreduced. (Note: Crowns and other major restorative services are not covered under Plan C-3.)

<table>
<thead>
<tr>
<th></th>
<th>DELTA DENTAL PPO</th>
<th>DELTA DENTAL PREMIER</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for procedure (crown)</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Amount approved by Delta Dental</td>
<td>$745</td>
<td>$1,450</td>
<td>N/A</td>
</tr>
<tr>
<td>How much the Plan pays (from Schedule of Dental Benefits)</td>
<td>$400</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>How much you pay</td>
<td>$345 ($745–$400)</td>
<td>$1,050 ($1,450–$400)</td>
<td>$1,600 ($2,000–$400)</td>
</tr>
</tbody>
</table>
What Is Covered

The Schedule of Dental Benefits, which begins on page 105, provides a complete list of covered dental services. In general, though, Plans C-1, C-2 and C-3 cover the following diagnostic and preventive services:

- oral examination, twice per calendar year
- prophylaxis (teeth cleaning), twice per calendar year
- x-rays, subject to annual x-ray maximum
- fluoride treatment for children (up to age 19), twice per calendar year
- sealant for children (up to age 19), for posterior permanent teeth, maximum once per calendar year.

In addition, Plans C-1 and C-2 cover additional services, such as:

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

Orthodontic services are not covered under the Plan.

Predetermination of Benefits

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

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

If you are considering major dental work, you may want to submit a predetermination of benefits.
Note. You should keep in mind that a pretreatment review estimate is not a promise of payment. The work must be done while the patient is still covered by the Plan, unless there is an “extension of benefits.”

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

- for crowns, fixed bridgework or full or partial dentures, and a pretreatment authorization was granted, impressions were taken and/or teeth were prepared while the patient was covered, and the device was installed or delivered within one month after that person’s coverage ended.

- for root canal therapy, and the pulp chamber of the tooth was opened while the patient was covered and the treatment was completed within one month after that person’s coverage ended.

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

What Is Not Covered

Expenses not covered under the Plan include expenses incurred as a result of:

- treatment solely for the purpose of cosmetic improvement

- replacement of a lost or stolen appliance

- replacement of a bridge, crown or denture within five years after it was originally installed; replacement of a bridge, crown or denture that is or can be made usable according to common dental standards

- orthodontic services

- procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) reposition teeth by orthodontic means

- multiple bridge abutments

- a surgical implant of any type

- services that do not meet common dental standards
• services not included in the Schedule of Dental Benefits
• work-related injury
• an accidental injury that is the responsibility of a third party
• a condition covered by Workers’ Compensation or a similar law for which the patient is eligible to receive coverage
• treatment in a hospital owned or run by the U.S. government, unless there is a legal obligation to pay those charges whether or not there is any insurance
• care for which charges would not have been made if the person had no insurance, including services provided by a member of the patient’s immediate family
• unnecessary care, treatment or surgery
• experimental procedures or treatment methods
• treatment for which payment is unlawful where the patient lives when the expenses are incurred
• treatment for which payment is available through a public program
• under Plan C-3 only, basic restorative services, major restorative services, oral surgery, endodontics, periodontics, prosthodontics and sealants.

Questions? Contact Delta Dental Member Services at 1-800-932-0783 or log on to www.deltadentalins.com/iatse.

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

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

This schedule shows the maximum amount that Plans C-1, C-2 and C-3 pays for dental services. If a procedure is not listed, it is not covered under any of the Plans.

**Coverage of Pediatric Diagnostic, Preventive and Basic Restorative Services:** The Fund will pay for pediatric (children under age 19) Diagnostic, Preventive and Basic Services at the Delta Dental PPO reimbursement rate, if that rate is higher than the scheduled amounts set forth below.

**DIAGNOSTIC:** Except where noted, these services are covered under Plans C-1, C-2 and C-3.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic oral evaluation—established patient</td>
<td>$28</td>
</tr>
<tr>
<td>Limited oral evaluation—problem focused</td>
<td>40</td>
</tr>
<tr>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>28</td>
</tr>
<tr>
<td>Comprehensive oral evaluation—new or established patient</td>
<td>28</td>
</tr>
<tr>
<td>Re-evaluation—limited, problem focused (established patient; not post operative visit)</td>
<td>28</td>
</tr>
<tr>
<td>Comprehensive periodontal evaluation—new or established patient</td>
<td>28</td>
</tr>
<tr>
<td>Intraoral—complete series (including bitewings)</td>
<td>70</td>
</tr>
<tr>
<td>Intraoral—periapical first film</td>
<td>8</td>
</tr>
<tr>
<td>Intraoral—periapical each additional film</td>
<td>5</td>
</tr>
<tr>
<td>Intraoral—occlusal film</td>
<td>15</td>
</tr>
<tr>
<td>Extraoral—first film</td>
<td>25</td>
</tr>
<tr>
<td>Extraoral—each additional film</td>
<td>25</td>
</tr>
<tr>
<td>Bitewing—single film</td>
<td>8</td>
</tr>
<tr>
<td>Bitewings—two films</td>
<td>13</td>
</tr>
<tr>
<td>Bitewings—three films</td>
<td>18</td>
</tr>
<tr>
<td>Bitewings—four films</td>
<td>23</td>
</tr>
<tr>
<td>Vertical bitewings—7 to 8 films</td>
<td>23</td>
</tr>
<tr>
<td>Posterior-anterior or lateral skull and facial bone survey film</td>
<td>30</td>
</tr>
<tr>
<td>Sialography (Plans C-1 and C-2 only)</td>
<td>45</td>
</tr>
<tr>
<td>Temporomandibular joint arthrogram, including injection (Plans C-1 and C-2 only)</td>
<td>45</td>
</tr>
<tr>
<td>Other temporomandibular joint films, by report (Plans C-1 and C-2 only)</td>
<td>45</td>
</tr>
<tr>
<td>Tomographic survey (Plans C-1 and C-2 only)</td>
<td>45</td>
</tr>
<tr>
<td>Panoramic film</td>
<td>55</td>
</tr>
<tr>
<td>Cephalometric film</td>
<td>55</td>
</tr>
<tr>
<td>Oral/facial photographic images</td>
<td>55</td>
</tr>
<tr>
<td>Palliative (emergency) treatment of dental pain—minor procedure</td>
<td>40</td>
</tr>
<tr>
<td>Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>50</td>
</tr>
<tr>
<td>Office visit for observation (during regularly scheduled hours)—no other services performed</td>
<td>28</td>
</tr>
</tbody>
</table>

**BASIC PREVENTIVE:** These services are covered under Plans C-1, C-2 and C-3.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis—adult</td>
<td>$50</td>
</tr>
<tr>
<td>Prophylaxis—child</td>
<td>35</td>
</tr>
<tr>
<td>Topical application of fluoride—child</td>
<td>17</td>
</tr>
</tbody>
</table>

**OTHER PREVENTIVE:** These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sealant—per tooth</td>
<td>$25</td>
</tr>
<tr>
<td>Space maintainer—fixed—unilateral</td>
<td>150</td>
</tr>
<tr>
<td>Space maintainer—fixed—bilateral</td>
<td>150</td>
</tr>
<tr>
<td>Space maintainer—removable—unilateral</td>
<td>150</td>
</tr>
<tr>
<td>Space maintainer—removable—bilateral</td>
<td>150</td>
</tr>
<tr>
<td>Recementation of space maintainer</td>
<td>50</td>
</tr>
<tr>
<td>Removal of fixed space maintainer</td>
<td>50</td>
</tr>
<tr>
<td>Removable appliance therapy</td>
<td>150</td>
</tr>
<tr>
<td>Fixed appliance therapy</td>
<td>150</td>
</tr>
</tbody>
</table>
### BASIC RESTORATIVE: These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam—one surface, primary or permanent</td>
<td>$60</td>
</tr>
<tr>
<td>Amalgam—two surfaces, primary or permanent</td>
<td>75</td>
</tr>
<tr>
<td>Amalgam—three surfaces, primary or permanent</td>
<td>85</td>
</tr>
<tr>
<td>Amalgam—four or more surfaces, primary or permanent</td>
<td>95</td>
</tr>
<tr>
<td>Resin-based composite—one surface, anterior</td>
<td>70</td>
</tr>
<tr>
<td>Resin-based composite—two surfaces, anterior</td>
<td>90</td>
</tr>
<tr>
<td>Resin-based composite—three surfaces, anterior</td>
<td>110</td>
</tr>
<tr>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
<td>110</td>
</tr>
<tr>
<td>Resin-based composite—one surface, posterior</td>
<td>75</td>
</tr>
<tr>
<td>Resin-based composite—two surfaces, posterior</td>
<td>100</td>
</tr>
<tr>
<td>Resin-based composite—three surfaces, posterior</td>
<td>115</td>
</tr>
<tr>
<td>Resin-based composite—four or more surfaces, posterior</td>
<td>125</td>
</tr>
<tr>
<td>Sedative filling</td>
<td>60</td>
</tr>
<tr>
<td>Pin retention—per tooth, in addition to restoration</td>
<td>25</td>
</tr>
</tbody>
</table>

### MAJOR RESTORATIVE: These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inlay—metallic—one surface</td>
<td>$225</td>
</tr>
<tr>
<td>Inlay—metallic—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—metallic—three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—metallic—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—metallic—three surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—metallic—four or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic—one surface</td>
<td>225</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic—three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic—three surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic—four or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—resin-based composite—one surface</td>
<td>225</td>
</tr>
<tr>
<td>Inlay—resin-based composite—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—resin-based composite—three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—resin-based composite—two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—resin-based composite—three surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—resin-based composite—four or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Crown—resin-based composite (indirect)</td>
<td>250</td>
</tr>
<tr>
<td>Crown—resin with high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—resin with predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—resin with noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—porcelain/ceramic substrate</td>
<td>375</td>
</tr>
<tr>
<td>Crown—porcelain fused to high noble metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—porcelain fused to predominantly base metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—porcelain fused to noble metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—3/4 cast high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 cast predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 cast noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 porcelain/ceramic</td>
<td>350</td>
</tr>
<tr>
<td>Crown—full cast high noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—full cast predominantly base metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—full cast noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—titanium</td>
<td>375</td>
</tr>
<tr>
<td>Recement inlay, onlay, or partial coverage restoration</td>
<td>40</td>
</tr>
<tr>
<td>Recement cast or prefabricated post and core</td>
<td>40</td>
</tr>
<tr>
<td>Recement crown</td>
<td>50</td>
</tr>
<tr>
<td>Prefabricated stainless steel crown—primary tooth</td>
<td>125</td>
</tr>
<tr>
<td>Prefabricated stainless steel crown—permanent tooth</td>
<td>125</td>
</tr>
<tr>
<td>Prefabricated resin crown</td>
<td>125</td>
</tr>
</tbody>
</table>
### MAJOR RESTORATIVE (continued)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefabricated stainless steel crown with resin window</td>
<td>125</td>
</tr>
<tr>
<td>Prefabricated esthetic coated stainless steel crown—primary tooth</td>
<td>125</td>
</tr>
<tr>
<td>Core buildup, including any pins</td>
<td>85</td>
</tr>
<tr>
<td>Post and core in addition to crown, indirectly fabricated</td>
<td>130</td>
</tr>
<tr>
<td>Prefabricated post and core in addition to crown</td>
<td>85</td>
</tr>
<tr>
<td>Labial veneer (resin laminate)—chairside</td>
<td>325</td>
</tr>
<tr>
<td>Labial veneer (resin laminate)—laboratory</td>
<td>325</td>
</tr>
<tr>
<td>Labial veneer (porcelain laminate)—laboratory</td>
<td>325</td>
</tr>
<tr>
<td>Crown repair, by report</td>
<td>90</td>
</tr>
</tbody>
</table>

### ORAL SURGERY: These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction, coronal remnants—deciduous tooth</td>
<td>$75</td>
</tr>
<tr>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>75</td>
</tr>
<tr>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td>145</td>
</tr>
<tr>
<td>Removal of impacted tooth—soft tissue</td>
<td>200</td>
</tr>
<tr>
<td>Removal of impacted tooth—partially bony</td>
<td>225</td>
</tr>
<tr>
<td>Removal of impacted tooth—completely bony</td>
<td>300</td>
</tr>
<tr>
<td>Removal of impacted tooth—completely bony, with unusual surgical complications</td>
<td>300</td>
</tr>
<tr>
<td>Surgical removal of residual tooth roots (cutting procedure)</td>
<td>150</td>
</tr>
<tr>
<td>Oroantral fistula closure</td>
<td>100</td>
</tr>
<tr>
<td>Surgical access of an unerupted tooth</td>
<td>100</td>
</tr>
<tr>
<td>Biopsy of oral tissue—hard (bone, tooth)</td>
<td>100</td>
</tr>
<tr>
<td>Biopsy of oral tissue—soft</td>
<td>100</td>
</tr>
<tr>
<td>Alveolectomy in conjunction with extractions—four or more teeth or tooth spaces, per quadrant</td>
<td>125</td>
</tr>
<tr>
<td>Alveolectomy in conjunction with extractions—one to three teeth or tooth spaces, per quadrant</td>
<td>75</td>
</tr>
<tr>
<td>Alveolectomy not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant</td>
<td>125</td>
</tr>
<tr>
<td>Alveolectomy not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant</td>
<td>75</td>
</tr>
<tr>
<td>Vestibuloplasty—ridge extension (secondary epithelialization)</td>
<td>125</td>
</tr>
<tr>
<td>Vestibuloplasty—ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue):</td>
<td>125</td>
</tr>
<tr>
<td>Excision of benign lesion up to 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Excision of benign lesion greater than 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Excision of benign lesion, complicated</td>
<td>75</td>
</tr>
<tr>
<td>Excision of malignant lesion up to 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Excision of malignant lesion greater than 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Excision of malignant lesion, complicated</td>
<td>75</td>
</tr>
<tr>
<td>Excision of malignant tumor—lesion diameter up to 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Excision of malignant tumor—lesion diameter greater than 1.25 cm</td>
<td>75</td>
</tr>
<tr>
<td>Removal of benign odontogenic cyst or tumor—lesion diameter up to 1.25 cm</td>
<td>125</td>
</tr>
<tr>
<td>Removal of benign odontogenic cyst or tumor—lesion diameter greater than 1.25 cm</td>
<td>150</td>
</tr>
<tr>
<td>Removal of benign nonodontogenic cyst or tumor—lesion diameter up to 1.25 cm</td>
<td>125</td>
</tr>
<tr>
<td>Removal of benign nonodontogenic cyst or tumor—lesion diameter greater than 1.25 cm</td>
<td>150</td>
</tr>
<tr>
<td>Destruction of lesion(s) by physical or chemical method, by report</td>
<td>75</td>
</tr>
<tr>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
<td>75</td>
</tr>
<tr>
<td>Removal of torus palatinus</td>
<td>75</td>
</tr>
<tr>
<td>Removal of torus mandibularis</td>
<td>75</td>
</tr>
<tr>
<td>Surgical reduction of osseous tuberosity</td>
<td>75</td>
</tr>
<tr>
<td>Incision and drainage of abscess—infraoral soft tissue</td>
<td>100</td>
</tr>
<tr>
<td>Incision and drainage of abscess—infraoral soft tissue—complicated</td>
<td>100</td>
</tr>
<tr>
<td>(includes drainage of multiple fascial spaces)</td>
<td>100</td>
</tr>
<tr>
<td>Incision and drainage of abscess—extraoral soft tissue</td>
<td>100</td>
</tr>
</tbody>
</table>
### ORAL SURGERY (continued)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces)</td>
<td>75</td>
</tr>
<tr>
<td>Maxillary sinusotomy for removal of tooth fragment or foreign body</td>
<td>75</td>
</tr>
<tr>
<td>Frenulectomy (frenectomy or frenotomy)—separate procedure</td>
<td>150</td>
</tr>
<tr>
<td>Excision of hyperplastic tissue—per arch</td>
<td>150</td>
</tr>
<tr>
<td>Excision of pericoronal gingiva</td>
<td>150</td>
</tr>
<tr>
<td>Surgical reduction of fibrous tuberosity</td>
<td>150</td>
</tr>
<tr>
<td>Sialolithotomy</td>
<td>150</td>
</tr>
<tr>
<td>Excision of salivary gland, by report</td>
<td>150</td>
</tr>
<tr>
<td>Sialodochoplasty</td>
<td>150</td>
</tr>
<tr>
<td>Closure of salivary fistula</td>
<td>150</td>
</tr>
<tr>
<td>Deep sedation/general anesthesia—first 30 minutes</td>
<td>150</td>
</tr>
<tr>
<td>Deep sedation/general anesthesia—each additional 15 minutes</td>
<td>150</td>
</tr>
<tr>
<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
<td>150</td>
</tr>
<tr>
<td>Intravenous conscious sedation/analgesia—first 30 minutes</td>
<td>150</td>
</tr>
<tr>
<td>Intravenous conscious sedation/analgesia—each additional 15 minutes</td>
<td>150</td>
</tr>
<tr>
<td>Non-intravenous conscious sedation</td>
<td>150</td>
</tr>
<tr>
<td>Therapeutic parenteral drug, single administration</td>
<td>30</td>
</tr>
<tr>
<td>Therapeutic parenteral drugs, two or more administrations, different medications</td>
<td>30</td>
</tr>
</tbody>
</table>

### ENDOdontics: These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulp cap—direct (excluding final restoration)</td>
<td>$30</td>
</tr>
<tr>
<td>Pulp cap—indirect (excluding final restoration)</td>
<td>30</td>
</tr>
<tr>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>85</td>
</tr>
<tr>
<td>Pulpal debridement, primary and permanent teeth</td>
<td>85</td>
</tr>
<tr>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
<td>85</td>
</tr>
<tr>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
<td>85</td>
</tr>
<tr>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
<td>85</td>
</tr>
<tr>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>350</td>
</tr>
<tr>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
<td>425</td>
</tr>
<tr>
<td>Endodontic therapy, molar tooth (excluding final restoration)</td>
<td>475</td>
</tr>
<tr>
<td>Treatment of root canal obstruction; non-surgical access</td>
<td>50</td>
</tr>
<tr>
<td>Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
<td>350</td>
</tr>
<tr>
<td>Internal root repair of perforation defects</td>
<td>350</td>
</tr>
<tr>
<td>Retreatment of previous root canal therapy—anterior</td>
<td>350</td>
</tr>
<tr>
<td>Retreatment of previous root canal therapy—bicuspide</td>
<td>425</td>
</tr>
<tr>
<td>Retreatment of previous root canal therapy—molar</td>
<td>475</td>
</tr>
<tr>
<td>Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>275</td>
</tr>
<tr>
<td>Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>275</td>
</tr>
<tr>
<td>Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>275</td>
</tr>
<tr>
<td>Apicoectomy/periapical surgery—anterior</td>
<td>275</td>
</tr>
<tr>
<td>Apicoectomy/periapical surgery—bicuspide (first root)</td>
<td>275</td>
</tr>
<tr>
<td>Apicoectomy/periapical surgery—molar (first root)</td>
<td>275</td>
</tr>
<tr>
<td>Apicoectomy/periapical surgery (each additional root)</td>
<td>275</td>
</tr>
<tr>
<td>Retrograde filling—per root</td>
<td>100</td>
</tr>
<tr>
<td>Root amputation—per root</td>
<td>150</td>
</tr>
<tr>
<td>Hemisection (including any root removal), not including root canal therapy</td>
<td>175</td>
</tr>
</tbody>
</table>
**NON-SURGICAL PERIODONTICS:** These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontal scaling and root planing—four or more teeth per quadrant</td>
<td>$70</td>
</tr>
<tr>
<td>Periodontal scaling and root planing—one to three teeth per quadrant</td>
<td>70</td>
</tr>
<tr>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>70</td>
</tr>
<tr>
<td>Periodontal maintenance</td>
<td>70</td>
</tr>
<tr>
<td>Occlusal guard, by report</td>
<td>150</td>
</tr>
<tr>
<td>Repair and/or relining of occlusal guard</td>
<td>75</td>
</tr>
<tr>
<td>Occlusal adjustment—limited</td>
<td>70</td>
</tr>
<tr>
<td>Occlusal adjustment—complete</td>
<td>70</td>
</tr>
</tbody>
</table>

**SURGICAL PERIODONTICS:** These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>$250</td>
</tr>
<tr>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>250</td>
</tr>
<tr>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>250</td>
</tr>
<tr>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>250</td>
</tr>
<tr>
<td>Apically positioned flap</td>
<td>250</td>
</tr>
<tr>
<td>Clinical crown lengthening—hard tissue</td>
<td>250</td>
</tr>
<tr>
<td>Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>375</td>
</tr>
<tr>
<td>Osseous surgery (including flap entry and closure)—one to three contiguous teeth or tooth bounded spaces, per quadrant</td>
<td>375</td>
</tr>
<tr>
<td>Bone replacement graft—first site in quadrant</td>
<td>350</td>
</tr>
<tr>
<td>Bone replacement graft—each additional site in quadrant</td>
<td>350</td>
</tr>
<tr>
<td>Guided tissue regeneration—resorbable barrier, per site</td>
<td>250</td>
</tr>
<tr>
<td>Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)</td>
<td>250</td>
</tr>
<tr>
<td>Pedicle soft tissue graft procedure</td>
<td>200</td>
</tr>
<tr>
<td>Free soft tissue graft procedure (including donor site surgery)</td>
<td>300</td>
</tr>
<tr>
<td>Subepithelial connective tissue graft procedures, per tooth</td>
<td>300</td>
</tr>
<tr>
<td>Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)</td>
<td>200</td>
</tr>
</tbody>
</table>
PROSTHODONTICS: These services are covered under Plans C-1 and C-2.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete denture—maxillary</td>
<td>$575</td>
</tr>
<tr>
<td>Complete denture—mandibular</td>
<td>575</td>
</tr>
<tr>
<td>Immediate denture—maxillary</td>
<td>575</td>
</tr>
<tr>
<td>Immediate denture—mandibular</td>
<td>575</td>
</tr>
<tr>
<td>Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)</td>
<td>325</td>
</tr>
<tr>
<td>Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)</td>
<td>325</td>
</tr>
<tr>
<td>Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>675</td>
</tr>
<tr>
<td>Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>675</td>
</tr>
<tr>
<td>Maxillary partial denture—flexible base (including any clasps, rests and teeth)</td>
<td>506</td>
</tr>
<tr>
<td>Mandibular partial denture—flexible base (including any clasps, rests and teeth)</td>
<td>506</td>
</tr>
<tr>
<td>Removable unilateral partial denture—one piece cast metal (including clasps and teeth)</td>
<td>300</td>
</tr>
<tr>
<td>Adjust complete denture—maxillary</td>
<td>50</td>
</tr>
<tr>
<td>Adjust complete denture—mandibular</td>
<td>50</td>
</tr>
<tr>
<td>Adjust partial denture—maxillary</td>
<td>50</td>
</tr>
<tr>
<td>Adjust partial denture—mandibular</td>
<td>50</td>
</tr>
<tr>
<td>Repair broken complete denture base</td>
<td>90</td>
</tr>
<tr>
<td>Replace missing or broken teeth—complete denture (each tooth)</td>
<td>75</td>
</tr>
<tr>
<td>Repair resin denture base</td>
<td>90</td>
</tr>
<tr>
<td>Repair cast framework</td>
<td>125</td>
</tr>
<tr>
<td>Repair or replace broken clasp</td>
<td>110</td>
</tr>
<tr>
<td>Replace broken teeth—per tooth</td>
<td>75</td>
</tr>
<tr>
<td>Add tooth to existing partial denture</td>
<td>75</td>
</tr>
<tr>
<td>Add clasp to existing partial denture</td>
<td>110</td>
</tr>
<tr>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
<td>110</td>
</tr>
<tr>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
<td>110</td>
</tr>
<tr>
<td>Rebase complete maxillary denture</td>
<td>250</td>
</tr>
<tr>
<td>Rebase complete mandibular denture</td>
<td>250</td>
</tr>
<tr>
<td>Rebase maxillary partial denture</td>
<td>250</td>
</tr>
<tr>
<td>Rebase mandibular partial denture</td>
<td>250</td>
</tr>
<tr>
<td>Reline complete maxillary denture (chairside)</td>
<td>130</td>
</tr>
<tr>
<td>Reline complete mandibular denture (chairside)</td>
<td>130</td>
</tr>
<tr>
<td>Reline maxillary partial denture (chairside)</td>
<td>125</td>
</tr>
<tr>
<td>Reline mandibular partial denture (chairside)</td>
<td>125</td>
</tr>
<tr>
<td>Reline complete maxillary denture (laboratory)</td>
<td>200</td>
</tr>
<tr>
<td>Reline complete mandibular denture (laboratory)</td>
<td>200</td>
</tr>
<tr>
<td>Reline maxillary partial denture (laboratory)</td>
<td>175</td>
</tr>
<tr>
<td>Reline mandibular partial denture (laboratory)</td>
<td>175</td>
</tr>
<tr>
<td>Tissue conditioning, maxillary</td>
<td>65</td>
</tr>
<tr>
<td>Tissue conditioning, mandibular</td>
<td>65</td>
</tr>
<tr>
<td>Pontic—cast high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—cast predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—cast noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—titanium</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—porcelain fused to high noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Pontic—porcelain fused to predominantly base metal</td>
<td>375</td>
</tr>
<tr>
<td>Pontic—porcelain fused to noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Pontic—porcelain/ceramic</td>
<td>375</td>
</tr>
<tr>
<td>Pontic—resin with high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—resin with predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Pontic—resin with noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Procedure Description</td>
<td>Maximum</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Retainer—cast metal for resin bonded fixed prosthesis</td>
<td>300</td>
</tr>
<tr>
<td>Retainer—porcelain/ceramic for resin bonded fixed prosthesis</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—cast high noble metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—cast high noble metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—cast predominantly base metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—cast predominantly base metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—cast noble metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Inlay—cast noble metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—cast high noble metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—cast high noble metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—cast predominantly base metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—cast predominantly base metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—cast noble metal, two surfaces</td>
<td>275</td>
</tr>
<tr>
<td>Onlay—cast noble metal, three or more surfaces</td>
<td>300</td>
</tr>
<tr>
<td>Inlay—porcelain/ceramic</td>
<td>300</td>
</tr>
<tr>
<td>Onlay—porcelain/ceramic</td>
<td>300</td>
</tr>
<tr>
<td>Crown—resin with high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—resin with predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—resin with noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—porcelain/ceramic</td>
<td>400</td>
</tr>
<tr>
<td>Crown—porcelain fused to high noble metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—porcelain fused to predominantly base metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—porcelain fused to noble metal</td>
<td>400</td>
</tr>
<tr>
<td>Crown—3/4 cast high noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 cast predominantly base metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 cast noble metal</td>
<td>350</td>
</tr>
<tr>
<td>Crown—3/4 porcelain/ceramic</td>
<td>350</td>
</tr>
<tr>
<td>Crown—full cast high noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—full cast predominantly base metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—full cast noble metal</td>
<td>375</td>
</tr>
<tr>
<td>Crown—titanium</td>
<td>375</td>
</tr>
<tr>
<td>Recement fixed partial denture</td>
<td>75</td>
</tr>
<tr>
<td>Post and core in addition to fixed partial denture retainer, indirectly fabricated</td>
<td>130</td>
</tr>
<tr>
<td>Prefabricated post and core in addition to fixed partial denture retainer</td>
<td>85</td>
</tr>
<tr>
<td>Core build up for retainer, including any pins</td>
<td>85</td>
</tr>
<tr>
<td>Fixed partial denture repair, by report</td>
<td>90</td>
</tr>
<tr>
<td>Pediatric partial denture, fixed</td>
<td>150</td>
</tr>
</tbody>
</table>
Benefits for Physical Exams and Hearing Aids

Two additional health care benefits are provided under Plans C-1 and C-2. Plan C-3 does not provide these benefits.

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

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

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

These benefits are administered by Administrative Services, Inc./Self-Insured Dental Services. If you have any questions contact ASO/SIDS at 1-516-396-5525 (in New York) or 1-877-390-5845 (outside New York).
Life Insurance Benefit

A life insurance benefit, provided through the United States Life Insurance Company in the City of New York (“AIG/US Life”), is available under Plans C-1 and Plan C-2. Plan C-3 does not provide life insurance. This benefit pays a lump sum to your survivors in the event of your death, from any cause, while you are covered under Plan C-1 or Plan C-2.

If you die while enrolled in Plan C-1 or C-2, your designated beneficiary or beneficiaries will receive a $20,000 life insurance benefit. AIG/US Life has the right to pay up to $500 of the $20,000 life insurance proceeds to a person it determines has incurred funeral or other expenses related to your last illness or death.

Naming a Beneficiary

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

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

- If two (2) or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

- If there is no designated beneficiary, or if no designated beneficiary is living after the insured’s death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is your estate.

- When a beneficiary dies before you, that person’s interest in your life insurance benefit automatically ends.

- In the event a beneficiary is a child, is mentally incapacitated or is otherwise unable to manage his or her affairs, and no legal guardian has been appointed, the Plan may pay any amount due to the party it believes is entitled to receive it on behalf of that individual.
• You may change your beneficiary designation at any time by completing a new beneficiary designation form (available online at www.iatsenbf.org) and sending it to the Fund Office. The change will be effective when the Fund Office receives the new form. You do not need anyone’s consent to change your beneficiary designation.

• Designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Fund Office will not be effective.

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

Consider your beneficiary designations and coverage elections under all your benefit plans if you have a change in family status, such as a marriage, separation, divorce, death or the birth or adoption of a child. Contact the Fund Office if you have any questions about the effect of these events under the National Benefit Funds.

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

Questions? If you have any questions about the life insurance benefit, contact the Fund Office at 1-212-580-9092 in New York or 1-800-456-FUND (3863) outside New York. For questions about a life insurance claim that has already been submitted to AIG/US Life, please call 1-800-250-8898.
Retiree Health Benefit Plan

Terms You Should Know...

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

While Plan coverage generally stops once you no longer meet the active eligibility requirements described on page 10, if you meet the requirements for retiree coverage, you will be entitled to the special retiree benefits described in this section.

Eligibility
You are entitled to retiree benefits if:

- your retirement started on or after January 1, 2001, at age 65 or older
- you are on Medicare
- you completed 15 calendar years of service under the Health & Welfare Fund
- four of your years of service under the Health & Welfare Fund were during the five calendar years immediately before you retired at age 65 or older.

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

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

If you return to work for an employer that contributes to the IATSE National Health & Welfare Fund and contributions made on your behalf equal at least one quarter of Plan C-3 single coverage, your retiree health benefits will be suspended. They can begin again only after you stop working and submit another application for retiree benefits. Please call the Fund Office if you return to work and/or need an application.
What the Benefit Is
If you meet the requirements described above, you will be entitled to:

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

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

Medicare Benefits
Medicare consists of four parts:

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

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

Special rules for participants enrolled in Plan C-MRP and Medicare are described on page 26.
How to Claim Benefits

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

• a copy of your Medicare card

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

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

• a copy of your insurance premium notice, with your full name and Social Security number included

• a copy of your canceled check.

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

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

• vision care benefits are provided through Davis Vision

• the hearing aid benefit is provided through ASO/SIDS.

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

Continuation of Benefits

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

If you have questions about retiree coverage, contact the Fund Office at 212-580-9092 in New York or 1-800-456-FUND (3863) outside New York.
Coordination of Benefits

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

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

Other Group Medical Plans

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

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

Which Plan Pays First

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

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

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are a participant in the Health & Welfare Fund and a dependent under the other plan, the Health & Welfare Fund Plan C is primary.
For a dependent child covered under both parents’ plans, the primary plan is determined as follows:

- The plan of the parent whose birthday comes earlier in the calendar year (month and day) is primary.

- The plan that has covered the parent for a longer period of time is primary, if the parents have the same birthday.

- The father’s plan is primary, if the other plan does not follow the “birthday rule” and uses gender to determine primary responsibility.

- If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child’s health care expenses), the plan covering the parent with custody is primary.

- If the parent with custody is remarried, his or her plan pays first, the stepparent’s plan pays second, and the non-custodial parent’s plan pays third.

- If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child’s health care expenses, that parent’s plan is primary, once the plan knows about the decree.

- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.

- If none of these rules apply, the plan that has covered the patient longest is primary.

**Tips for Coordinating Benefits**

To receive all the benefits available to you, file your claim under each plan.

File claims first with the primary plan, then with the secondary plan.

Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.
**Medicare.** Different COB rules apply for active employees and spouses of active employees covered by our Plan who are also Medicare eligible. This Plan always pays first unless you or your spouse rejects this coverage and chooses Medicare as primary coverage, which means Medicare pays first. However, if you or your spouse does this, the Plan will not pay any difference between the benefits paid by Medicare and the amount that is actually charged. In other words, you will be waiving coverage under this Plan, which means you will have no coverage for expenses that are covered by this Plan, but not by Medicare.

For disabled participants and disabled covered dependents of active participants who are under age 65 but are also eligible for Medicare, this Plan pays first until age 65. This Plan also pays first during the first 30 months of end-stage renal disease. Special rules for participants enrolled in Plan C-MRP and Medicare are described on page 26.
Claims and Appeals Procedures

Terms You Should Know...

- **Adverse determination** is a communication from Empire’s Medical Management that reduces or denies benefits.

- **Beneficiary** means the person you name to receive any benefits provided by the Plan if you die.

- **ERISA** means the Employee Retirement Income Security Act of 1974. This act established certain rights to obtain information and protections for participants in all benefit plans. It also imposes duties upon the people who are responsible for the administration of health plans.

- **Itemized bill** is a bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient’s name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider’s name and address and descriptions of each service, while a hospital bill will have the subscriber’s name and address, the patient’s date of birth and the plan holder’s Empire identification number. Ambulance bills will include the patient’s full name and address, date and reason for service, total mileage traveled and charges.

- **Medically necessary** means services, supplies or equipment provided by a hospital or other provider of health services that are:
  - consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury,
  - in accordance with standards of good medical practice,
  - not solely for the convenience of the patient, the family or the provider,
  - not primarily custodial, and
  - the most appropriate level of service that can be safely provided to the patient. The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

This section describes the procedures for filing claims for benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision. If you are covered by Triple-S PPO, the procedures for filing hospital, medical and prescription drug claims and appeals may be different and are described in materials from Triple-S.
Definition of a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan’s reasonable claims procedures including filing a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. A specific request for eligibility relating to a particular person or period shall be treated as a claim under these procedures. Simple inquiries about the Plan’s provisions or about Plan eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim.

Where to File Claims

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

Send completed hospital claims to:

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

Send completed medical claims to:

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

You can check the status of a claim, view and print an Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night by visiting www.empireblue.com.
Here are important tips about filing claims:

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

File claims within 18 months of the date of service to receive benefits.

If you are enrolled in the Triple-S PPO, there may be situations in which you need to make a claim for reimbursement. To make a claim, send the original payment receipt to:

Triple-S, Inc.
Reimbursement Section
Box 363628
San Juan, PR 00936-3628

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

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

Vision Care Processing Unit
P.O. Box 1525
Latham, New York 12110
**Dental Benefits.** A claim form for out-of-network dental services is available online at www.iatsenbf.org or from the Fund Office.

For Delta Dental, send the completed form to:

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

For ASO/SIDS, send the completed form to:

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

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

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

**Plan C-MRP (Medical Reimbursement Program).** How you file your claim depends on which type of claim you are making — for a health care insurance premium or for an expense that is not covered in full under your health care coverage. See page 31 for details. A claim form for Plan C-MRP is available online at www.iatsenbf.org or from the Fund Office. Send the completed form to:

ASO/SIDS  
P.O. Box 9005, Dept. 51  
Lynbrook, NY 11563-9005

**Life Insurance Benefits or Eligibility.** Contact the Fund Office at:

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

**When Claims Must Be Filed**

Medical claims must be filed within 18 months following the date the charges were incurred. Dental claims must be filed within 12 months after the date of service. Plan C-MRP claims must be filed within three months following the end of the calendar year in which the claims were incurred. A life insurance claim must be filed within 18 months of the date of death. Prescription claims must be filed within 365 days of the date the prescription was filled. Vision claims must be filed within 18 months of the date of service.
Authorized Representatives

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

Claims Procedures

The claims procedures for hospital, medical, dental, vision, prescription drug, physical exam and hearing aid benefits and medical reimbursement will vary depending on whether you are making a preservice claim, an urgent care claim, a concurrent care claim or a post service claim. The procedures for life insurance claims also vary. Empire’s procedures are described beginning on page 88. The procedures for other providers are described below.

Preservice and Urgent Care Claims

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

If you fail to precertify a service that requires advance approval, certain penalties may apply or you may not receive any benefits at all.

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

For properly filed preservice claims, you and your health care provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the health organization. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.
If an extension is needed because the health organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The health organization then has 15 days (from the date it receives your response) to make a decision and notify you of the determination. You have the right to appeal a denial of your pre-service claim. (See Review Process and Timing of Notice of Decision on Appeal on pages 130 and 131.)

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

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

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

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

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

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

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

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

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

**Postservice Claims**

A postservice claim is a claim submitted for payment after health services and treatment have been obtained. To make a postservice claim:

- Obtain a claim form.
- Complete the employee’s portion of the claim form.
- Have your physician either complete the Attending Physician’s Statement section of the claim form, submit a completed HCFA-1500 health insurance claim form or submit a HIPAA-compliant electronic claims submission.
- Attach all itemized hospital bills or doctor’s statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Ordinarily, you will be notified of the decision on your postservice claim within 30 days from receipt of the claim by the health organization. This period may be extended one time by the health organization for up to 15 days if the extension is necessary due to matters beyond the control of the health organization. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the health organization expects to render a decision.
If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The health organization then has 15 days from the date it receives the requested information to make a decision on a postservice claim and notify you of the determination.

Life Insurance Claims

A life insurance claim is a claim made by your beneficiary on the occasion of your death. Claim forms and instructions for completing the form may be obtained from the Fund Office. All claim forms must be completed in accordance with the instructions and mailed to the Fund Office. The Fund Office will forward the claim to AIG/US Life for processing. The claim form should be completed by the beneficiary, or if there is no named or surviving beneficiary, then by the surviving family member(s) entitled to the benefit (see page 89). If the individual entitled to the benefit is a minor, the claim form should be completed and signed by Guardian of the Property of such minor and certified guardianship papers should also be submitted. If the benefit is payable to the estate, then the claim form should be completed by the executor.

Once the Fund Office receives the claim and forwards it to AIG/US Life, AIG/US Life will notify the beneficiary that the claim has been received and is being reviewed. The beneficiary will be instructed to call the AIG/US Life Claims Department at 800-250-8898 for any questions. AIG/US Life will make a decision on the claim and notify your beneficiary within 90 days of its receipt of the completed claim form and all required documentation. If AIG/US Life requires an extension of time due to matters beyond its control, it will notify your beneficiary of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time AIG/US Life notifies your beneficiary of the delay. If an extension is needed because additional information is needed from your beneficiary, the extension notice will specify the information needed. Until your beneficiary supplies this additional information, the normal period for making a decision on the claim will be suspended.

Eligibility Claims

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

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

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or any other adverse benefit determination. This notice will include:

- information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- the specific reason(s) for the determination, and, upon request, the denial code, if applicable
- a description of the Plan’s standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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

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

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

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

Request for Review of Denied Claim

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

Appeals are made to the specific health organization that processed the claim, except for appeals of eligibility claims, which are made to the Fund Office for review by the Board of Trustees of the Fund.
The name, address and telephone number of the Fund Office and of all the health organizations that service the Plan are listed earlier in this section. However, appeals of hospital or medical claims denied by Empire (including requests for External Reviews), should be sent to the following address:

Empire BlueCross and BlueShield  
P.O. Box 11825  
Appeals Department Mail Drop 6/0  
Albany, NY 12211

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

An appeal involving an urgent care claim may be made orally to the Fund Office (for prescription appeals only) or to the health organization that administers the particular benefit.

Review Process

The review process works as follows:

• You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office or health organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the benefit determination); it demonstrates compliance with the Fund Office’s or health organization’s administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

• Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office or health organization on your claim, without regard to whether their advice was relied upon in deciding your claim.

• Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

• If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

• You will also be provided free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on review is denied based on a new or additional rationale, you will receive the rationale, free of charge.
Timing of Notice of Decision on Appeal

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

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

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

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

---

**You will receive verbal notice of the decision of an urgent concurrent appeal, followed by written notification. Non-urgent appeals will result in written notification only.**

**Postservice Medical, Hospital, Prescription Drug, Dental and Vision Claims.** Empire BlueCross BlueShield, CVS Caremark, Delta Dental, ASO/SIDS and Davis Vision offer two levels of appeal for postservice claims. Each level of appeal will be decided within **30 days.** If you are dissatisfied with the outcome of your first appeal, you may file a second appeal. The second appeal must be filed within **180 days** of your receipt of the decision regarding the first appeal. All decisions will be in writing. If you are enrolled in the Triple S PPO (or equivalent plan) in Puerto Rico, contact your provider directly for information about claims and appeals procedures. You must exhaust both levels of review in order to be eligible for External Review. See the External Review section on page 133 for more information.

**Life Insurance Claims.** Appeals of denials of life insurance claims must be mailed to AIG/US Life. AIG/US life will make a decision within **60 days** following receipt of your request for review. If there are special circumstances which require an extension of time (up to an additional 60 days), AIG/US Life will provide written notification of the delay. The final decision will be made in writing, clearly stating the reasons for the decision and the provision of the Plan on which the decision is based.
Eligibility and Medical Reimbursement Claims. Eligibility and medical reimbursement claims appeals are directed to the Board of Trustees of the Fund, which will provide one level of appeal. Ordinarily, decisions on appeals involving eligibility claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice of Decision on Review

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

- information sufficient to identify the claim involved (including, if applicable, the date of service, the health care provider, and the claim amount)
- the specific reason(s) for the determination, and, upon request, the denial code, if applicable
- a description of the Plan’s standard, if any, that was used in denying the claim (in the case of a notice of final internal adverse benefit determination, this description will include a discussion of the decision)
- reference(s) to the specific Plan provision(s) on which the determination is based
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- a statement describing the Plan’s voluntary appeal procedures and your right to obtain the information about such procedures
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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

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

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

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

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

When to request External Review. You must submit your request for External Review within four months of the notice that your claim was denied after the second level of review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the health organization’s decision, can be sent between the health organization and you by telephone, facsimile or other similar method.

How to request External Review. A request for External Review must be in writing unless the applicable health organization determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for the review of your claim denial. However, you are encouraged to submit any additional information that you think is important for review.
How to request an Expedited External Review. To proceed with an Expedited External Review, you or your authorized representative must contact the health organization that denied your claim on review and provide at least the following information:

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

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

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

Limitation on When a Lawsuit May Be Started

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

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

Subrogation

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

• The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you or your eligible dependents are fully compensated, and regardless of whether the payments you or your eligible dependents receive make you or your eligible dependents whole for your losses, illnesses and/or injuries.

• You or your eligible dependents and any legal representative of you or your eligible dependents must do whatever is necessary to enable the Plan to exercise the Plan’s rights and do nothing to prejudice those rights.

• In the event that you or your eligible dependents or legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

• The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

• To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan’s subrogation claim and any claim held by you or your eligible dependents, the Plan’s subrogation claim shall be first satisfied before any part of a recovery is applied to your or your eligible dependents’ claim, attorney fees, other expenses or costs. The Plan does not recognize the “Make Whole” Doctrine.

• The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you or your eligible dependents incur without the Plan’s prior written consent. The Plan expressly rejects the “Common Fund” Doctrine. Accordingly, the “Common Fund” doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
Reimbursement

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

• You or your eligible dependents must reimburse the Plan from any recovery to the extent of benefits the Plan paid on behalf of you or your eligible dependents regardless of whether the payments you receive make you whole for your or your eligible dependents’ losses, illnesses and/or injuries.

• Notwithstanding any allocation or designation of your or your eligible dependents’ recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan’s rights will not be reduced due to your negligence.

• You or your eligible dependents and any legal representative of you or your eligible dependents must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon receipt of the recovery. You or your eligible dependents must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “Common Fund” Doctrine does not apply to any funds recovered by any attorney you or your eligible dependents hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

• If you or your eligible dependents fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your or your eligible dependents’ recovery, whichever is less, from any future benefit under the Plan if:

  – the amount the Plan paid on your or your eligible dependents’ behalf is not repaid or otherwise recovered by the Plan, or

  – you or your eligible dependents fail to cooperate.

• In the event that you or your eligible dependents fail to disclose to the Plan the amount of any settlement, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.

• The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your or your eligible dependents’ recovery, whichever is less, directly from the providers to whom the Plan has made payments on your or your eligible dependents’ behalf. In such a circumstance, it may then be your obligation to pay the provider the full-billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.

• The Plan does not recognize the “Make Whole” Doctrine and, therefore, is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or your eligible dependents or make you or your eligible dependents whole.
Your Duties

• You or your eligible dependents must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you or your eligible dependents occurred and all information regarding the parties involved.

• You or your eligible dependents must cooperate with the Plan in the investigation, settlement and protection of the Plan’s rights. In the event that you or your eligible dependents or any legal representative of you or your eligible dependents fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

• You or your eligible dependents must not do anything to prejudice the Plan’s rights.

• You or your eligible dependents must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you or your eligible dependents.

• You or your eligible dependents must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on behalf of you or your eligible dependents.

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

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

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

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

Illegal activity adds to everyone’s cost for health care. If you know of any person receiving Empire benefits that he or she is not entitled to, call Empire at 1-800-423-7283. Your identity will be kept confidential.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Term You Should Know...

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

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

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

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

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

- The Board of Trustees understands that the Plan will only disclose health information to the Board of Trustees for the Trustees’ use in Plan administration functions.
- Unless it has your written permission, the Board of Trustees will only use or disclose PHI for Plan administration, or as otherwise permitted by this Summary Plan Description, or as required by law.
• The Board of Trustees will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.

• The Board of Trustees will not use or disclose your PHI for any employment-related actions or decisions, or with respect to any other pension or other benefit plan sponsored by the Board of Trustees without your specific written permission.

• The Board of Trustees will report to the Plan’s Privacy Officer if the Trustees become aware of any use or disclosure of PHI that is inconsistent with the provisions set forth in this Summary Plan Description.

• The Board of Trustees will allow you, through the Plan, to inspect and photocopy your PHI, to the extent, and in the manner, required by HIPAA.

• The Board of Trustees will make available PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA.

• The Board of Trustees will keep a written record of certain types of disclosures it may make of PHI, so that it may make available the information required for the Plan to provide an accounting of certain types of disclosures of PHI.

• The following categories of employees under the control of the Board of Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:
  – Executive Director
  – all department directors
  – Health & Welfare Fund staff
  – other staff as needed for their jobs.

• These employees will be permitted to have access to and use the PHI only to perform the Plan administration functions that the Board of Trustees provides for the Plan.

• The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the participants whose privacy has been violated.

• The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Plan in order to allow the Secretary to determine the Plan’s compliance with HIPAA.

• The Board of Trustees will return to the Plan or destroy all your PHI received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
There are also some special rules under HIPAA related to “electronic health information.” Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

The Board of Trustees has taken additional steps with respect to the implementation of security measures for electronic protected health information, as follows:

- The Board of Trustees has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health Plan.

- The Board of Trustees has ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures.

- The Board of Trustees has ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

- The Board of Trustees will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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

Genetic Information Non-Discrimination Act (GINA)

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

Board of Trustees

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

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

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

The Board of Trustees also reserves the right in its sole and absolute discretion to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan’s termination (which might occur if the Union and the employers negotiate the discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Fund assets have been disbursed. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and IATSE representatives.
Collective Bargaining Agreement and Contributing Employers

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

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

Recovery of Overpayments

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

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

Assignment of Plan Benefits

Except as otherwise specifically set forth elsewhere in this Plan, authorized by the Plan in writing or required by law, any attempt to assign benefits or rights (including, without limitation, rights to sue) under this Plan are prohibited, whether or not the Plan has made any benefits payments to any third parties.
## Plan Facts

<table>
<thead>
<tr>
<th>Official Plan Name</th>
<th>IATSE National Health &amp; Welfare Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Identification Number (EIN)</td>
<td>13-3088695</td>
</tr>
<tr>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1–December 31</td>
</tr>
<tr>
<td>Type of Plan</td>
<td>An employee welfare benefit plan that provides medical, prescription drug, vision, dental and life insurance benefits</td>
</tr>
<tr>
<td>Effective Date</td>
<td>This Summary contains the rules in effect as of November 1, 2012.</td>
</tr>
<tr>
<td>Funding of Benefits</td>
<td>The benefits described in this booklet are provided through employer contributions and, in some cases, employee contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of contribution. The Fund Office will provide to participants and beneficiaries, upon written request and as required by law, information as to whether a particular employer is contributing to the Fund on behalf of employees. The amount of any employee contributions made is determined as the difference between the cost of the applicable coverage and the amount of any employer contributions received on the employee’s behalf. Currently, medical benefits, hospitalization, prescription drug, dental, physical exam, hearing aid and medical reimbursement benefits are self-funded, which means they are paid directly out of Fund assets, rather than through an insurance policy. In most cases, the Fund has contracted with outside providers to administer these benefits. Life insurance benefits are insured through the United States Life Insurance Company (“AIG/US Life”) and in Puerto Rico through AIG/AGL. Vision benefits are insured through Davis Vision.</td>
</tr>
<tr>
<td>Trust Fund</td>
<td>All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses. The Fund’s assets are invested in various investment options and are deposited or invested with banks according to guidelines and objectives adopted by the Board of Trustees.</td>
</tr>
<tr>
<td>Plan Sponsor &amp; Administrator</td>
<td>The IATSE National Health &amp; Welfare Fund is sponsored and administered by a joint Board of Trustees composed of Union trustees and employer trustees. Employer trustees are selected by the employer associations. Union trustees are designated by the Union. The names and addresses of the Trustees appear in this booklet. They may be contacted at: IATSE National Health &amp; Welfare Fund 417 Fifth Avenue, 3rd Floor New York, NY 10016-2204 1-212-580-9092 1-800-456-FUND (3863)</td>
</tr>
<tr>
<td>Participating Employers</td>
<td>The IATSE National Health &amp; Welfare Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Plan on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and union locals sponsoring the Plan may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.</td>
</tr>
<tr>
<td>Agent for Service of Legal Process</td>
<td>In the event of a legal dispute involving the Plan, legal documents may be served on: Anne J. Zeisler, Executive Director IATSE National Health &amp; Welfare Fund 417 Fifth Avenue, 3rd Floor New York, NY 10016-2204 Legal process may also be served on any individual Trustee at the Fund Office address. For disputes arising under those portions of the Plan insured by AIG/US Life or Davis Vision, service of legal processes may be made upon the applicable insurer at one of their local offices or upon the official of the Insurance Department in the state in which you reside.</td>
</tr>
</tbody>
</table>
Your Rights under the Employee Retirement Income Security Act of 1974 (ERISA)

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including Summary Plan Descriptions, collective bargaining agreements and a copy of the latest annual report (Form 5500 series).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, the latest annual report (Form 5500 series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

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

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

Assistance with Your Questions

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

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

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

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>ADMINISTRATOR/INSURER</th>
<th>TYPE OF FUNDING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL AND HEALTH</strong></td>
<td>Empire BlueCross BlueShield</td>
<td>Self-funded. The Fund pays the cost of benefits, which are administered by Empire BlueCross BlueShield.</td>
</tr>
<tr>
<td></td>
<td>PPO Member Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1407</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Church Street Station</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New York, NY 10008-1407</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-553-9603 (TDD for hearing impaired)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8:30 am to 5 pm weekdays</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.empireblue.com">www.empireblue.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BlueCard® PPO Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-810-BLUE (2583)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.bcbs.com">www.bcbs.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Management Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-982-8089</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8:30 am to 5 pm weekdays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24/7 NurseLine and AudioHealth Library</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-877-TALK-2RN (825-5276)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fraud Hotline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-I-C FRAUD (423-7283)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 am to 5 pm weekdays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triple-S, Inc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Box 363628</td>
<td></td>
</tr>
<tr>
<td></td>
<td>San Juan, PR 00936-3628</td>
<td></td>
</tr>
<tr>
<td><strong>PLAN C-MRP (MEDICAL REIMBURSEMENT PROGRAM)</strong></td>
<td>ASO/SIDS</td>
<td>Self-funded. Fund pays cost of benefits, which are administered under a contract with ASO/SIDS.</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 9005, Dept. 51</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lynbrook, NY 11563-9005</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-516-396-5500 (NY)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-537-1238 (outside NY)</td>
<td></td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUG</strong></td>
<td>CVS Caremark</td>
<td>Self-funded. Fund pays cost of benefits, which are administered by Caremark.</td>
</tr>
<tr>
<td></td>
<td>Caremark Claims Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See claim form for address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-929-2524</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CVS Caremark Mail Service Pharmacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2110</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15230-2110</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caremark.com</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>ADMINISTRATOR/INSURER</td>
<td>TYPE OF FUNDING</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>VISION CARE</td>
<td>Davis Vision</td>
<td>The Fund pays premiums to Davis Vision, and Davis Vision provides coverage.</td>
</tr>
<tr>
<td></td>
<td>Capital Region Health Park, Suite 301</td>
<td></td>
</tr>
<tr>
<td></td>
<td>711 Troy-Schenectady Road</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Latham, NY 12110</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-999-5431</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.davisvision.com">www.davisvision.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lens 1-2-3®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-LENS-123 (536-7123)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.Lens123.com">www.Lens123.com</a></td>
<td></td>
</tr>
<tr>
<td>DENTAL</td>
<td>Delta Dental</td>
<td>Self-funded. Fund pays cost of benefits, which are administered by Delta Dental</td>
</tr>
<tr>
<td></td>
<td>One Delta Drive</td>
<td>and ASO/SIDS.</td>
</tr>
<tr>
<td></td>
<td>Mechanicsburg, PA 17055-6999</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-932-0783</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.deltadentalins.com/iatse">www.deltadentalins.com/iatse</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ASO/SIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 9005, Dept. 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lynbrook, NY 11563-9005</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-537-1238</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.asonet.com">www.asonet.com</a></td>
<td></td>
</tr>
<tr>
<td>PHYSICAL EXAMS AND HEARING AIDS</td>
<td>ASO/SIDS</td>
<td>Self-funded. Fund pays cost of benefits, which are administered under a contract with ASO/SIDS.</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 9005, Dept. 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lynbrook, NY 11563-9005</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-516-396-5525 (NY)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-877-390-5845 (outside NY)</td>
<td></td>
</tr>
<tr>
<td>LIFE INSURANCE</td>
<td>AIG Benefit Solutions/US Life</td>
<td>Insured. Fund pays premiums to AIG/US Life (AIG/AGL in Puerto Rico) to provide coverage.</td>
</tr>
<tr>
<td></td>
<td>Attention of Life Claims</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department 2-K</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3600 Rt. 66</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neptune, NJ 07753</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-250-8898</td>
<td></td>
</tr>
<tr>
<td></td>
<td>417 Fifth Avenue, 3rd Floor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New York, NY 10016-2204</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-212-580-9092</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-456-FUND (3863)</td>
<td></td>
</tr>
</tbody>
</table>
Glossary

This section provides definitions of important terms used in this booklet to help you better understand your health benefits and how they work.

**360° Health** is a program that provides you with personalized support through online health and wellness resources, discounts on health-related products and services and alternative therapies.

**Adverse determination** is a communication from Empire’s Medical Management that reduces or denies benefits.

**Affiliated Local** is a local union chartered by or affiliated with the Union.

**Annual Enrollment**, which runs from mid-November through December 15 each year, is the only time of year you can change your level of coverage (unless you experience a qualifying event such as marriage or the birth of a child). If you make a change during **Annual Enrollment**, it will become effective the following January 1.

**Annual maximum** is the maximum amount the Plan will pay for covered expenses in one calendar year.

**Annual out-of-pocket coinsurance maximum** is the most you will have to pay in out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the Plan pays 100% of the maximum allowed amount for covered expenses for the remainder of that calendar year. Deductibles, copays, the coinsurance for behavioral health care expenses and any amount you pay above the out-of-network maximum allowed amount do not count toward the annual out-of-pocket coinsurance maximum.

**Automatic downgrade** is an automatic reduction in your coverage if the coverage you want requires a self-payment and you fail to make the payment (or it is received after the applicable deadline).

**Automatic enrollment** occurs if you do not enroll during optional enrollment and contributions to your account are sufficient to cover the $150 administrative fee plus the current quarterly charge for Plan C-2 single coverage.

**Beneficiary** means the person you name to receive any benefits provided by the Plan if you die.

**Brand-name drug** refers to a prescription drug sold under the registered or trademarked name given to it by the drug manufacturer that holds the manufacturing and marketing rights to that drug.
**CAPP (Contributions Available for Premium Payments) account** refers to an account in your name that tracks the amount of employer contributions received on your behalf for coverage under Plan C.

**Case Management** refers to assistance and support available when you or a member of your family faces a chronic or catastrophic illness or injury.

**Certificate of Creditable Coverage** is a notice you receive when your coverage ends that indicates the period of time you were covered under the Plan. You may need the Certificate when you enroll in a new plan or apply for coverage on your own.

**Change in family status** is an event (such as marriage, divorce or the birth of a child) that allows you to change your enrollment election soon after the event occurs.

**Coinsurance** is the percentage of a covered medical expense you pay.

**Collective bargaining agreement** means a negotiated agreement between an employer and the Union or an Affiliated Local requiring contributions to the IATSE National Health & Welfare Fund. It determines the amount of contributions employers are required to make to the Fund for work in covered employment.

**Combining CAPP accounts** refers to a provision under Plan C that allows two Plan C participants who are married or domestic partners to direct employer contributions received on behalf of either of them to a single account.

**Concurrent** refers to a claim or review during treatment.

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

**Contributing employer** is an employer that has signed a collective bargaining agreement with the Union or an Affiliated Local. The Fund, the Union and Affiliated Locals may be contributing employers if they contribute to the IATSE National Health & Welfare Fund pursuant to a written agreement.

**Copay** is the fee you pay for office visits and certain covered services when you use in-network providers.

**Coverage lapse** refers to a termination of all coverage under the Plan because your CAPP account balance is insufficient to cover the quarterly cost of the lowest-cost option and you fail to make a timely self-payment.

**Coverage quarter** refers to three consecutive months of a calendar quarter (January-March, April-June, July-September, October-December) during which you are enrolled in Plan C.

**Covered employment** means work covered by a collective bargaining agreement or another agreement that requires your employer to make contributions to the IATSE National Health & Welfare Fund Plan C on your behalf.
Covered services are services for which the Plan pays benefits. Certain frequency or other limitations may apply.

CVS Caremark Mail Service Pharmacy is the prescription drug mail service under the Plan through which you can fill your and your enrolled dependents’ prescriptions for most maintenance and long-term drugs (those taken for more than 30 days).

Deductible is the dollar amount you must pay each calendar year before the Plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, Plan C-1 and Plan C-2 will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. (Plan C-3 does not cover out-of-network services.) The exception to this rule is a common accident benefit—if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

Dependent children are natural children, stepchildren, children required to be recognized under a QMCSO and adopted children (including children to be adopted during a waiting period before finalization of the adoption) who are dependent on you for financial support.

Domestic partners are two adults of the same sex who meet the Plan’s definition of domestic partners on page 12. Same-sex spouses are considered domestic partners.

Employee means someone working under a collective bargaining agreement with a contributing employer. Employee may include a full-time Fund employee, office and clerical employee and duly elected or appointed officer of the Union or an Affiliated Local if the respective Fund, Union or Affiliated Local is a contributing employer.

Employer contribution period refers to the three consecutive months during which contributions received by the Fund Office on your behalf are applicable to a particular coverage quarter. For example, contributions received from August through October are applicable to the coverage quarter from January through March.

Employer contributions are amounts that employers contribute to the Health & Welfare Fund on behalf of employees who are covered by the IATSE National Health & Welfare Plan C.

ERISA means the Employee Retirement Income Security Act of 1974. This act established certain rights to obtain information and protections for participants in all benefit plans. It also imposes duties upon the people who are responsible for the administration of health plans.

Family and Medical Leave Act (FMLA) refers to the law that allows you to take unpaid time off for your own or a family member’s serious illness or to take care of new baby.

Forfeiture is what happens if there is no activity in a CAPP account for two consecutive calendar years. The balance in the account is forfeited.

Generic drug refers to a lower-cost equivalent of a brand-name drug. It is approved by the U.S. Food and Drug Administration (FDA) and has the same active ingredients as its brand-name equivalent.
Hospital/facility means, for purposes of certifying inpatient services under the Empire portion of the Plan, a hospital or facility that is a fully licensed acute-care general facility, and has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care
- Assigned emergency personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with either Empire or another BlueCross and/or BlueShield plan. For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Empire or participating with Empire or another BlueCross and/or BlueShield plan other than specified above. For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another BlueCross and/or BlueShield plan. In other states, the facility must participate with another BlueCross and/or BlueShield plan and be certified by the state using criteria similar to New York’s. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate. For behavioral health care purposes, the definition of “hospital” may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral health care services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations. For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with Empire. Empire does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.
**In-network benefits** are benefits for covered services delivered by in-network providers and suppliers, hospitals and other health care facilities. Services provided must fall within the scope of their individual professional licenses.

**In-network provider/supplier/hospital/facility** for Empire is a doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier, hospital or other facility that:

- is in Empire’s PPO network
- is in the network of another BlueCross and/or BlueShield plan, or
- has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a network.

**Itemized bill** is a bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider’s name and address and descriptions of each service, while a hospital bill will have the subscriber’s name and address, the patient’s date of birth and the Plan holder’s Empire identification number. Ambulance bills will include the patient’s full name and address, date and reason for service, total mileage traveled and charges.

**Maximum allowed amount** is the maximum amount the Plan reimburses for services and supplies. In-network providers have agreed to accept the maximum allowed amount as payment in full for services. Out-of-network providers may bill you for amounts above the maximum allowed amount and you will be responsible for paying any amount charged above the maximum allowed amount. For more detail on the maximum allowed amount see the section “How Much You Will Pay—Maximum Allowed Amount” on page 57.

**Medically necessary** means services, supplies or equipment provided by a hospital or other provider of health services that are:

- consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury
- in accordance with standards of good medical practice
- not solely for the convenience of the patient, the family or the provider
- not primarily custodial, and
- the most appropriate level of service that can be safely provided to the patient.

The fact that an in-network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

**Optional enrollment** refers to your first opportunity to enroll in Plan C, which occurs when contributions to your account are sufficient to cover the $150 administrative fee plus the current monthly charge for Plan C-2 single coverage.
Out-of-network benefits refers to benefits for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance, which means higher out-of-pocket costs for participants.

Out-of-network providers/supplier/hospital/facility is a doctor or other professional provider, durable medical equipment, home health care or home infusion supplier, hospital or other facility that:

- is not in Empire’s network
- is not in the network of another BlueCross and/or BlueShield plan, and
- does not have a negotiated rate with another BlueCross and/or BlueShield plan.

Participation termination means you lose your eligibility for participation in Plan C because your CAPP account balance for the next coverage quarter is zero and, over the preceding 24 months, contributions made by employers on your behalf have been less than the quarterly charge for Plan C-2 single coverage.

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

Plan C-MRP (Medical Reimbursement Program) is an option under Plan C that that helps you pay for health care expenses in one of two ways. If you provide acceptable proof that you have other medical coverage, you can enroll in Plan C-MRP as a standalone option and use your entire account balance for eligible medical expenses. If you enroll in Plan C-1, C-2 or C-3 and there is “excess” funding in your CAPP account, you can use Plan C-MRP as a supplemental option for eligible medical expenses. Excess funding refers to any amount in your account as of the end of the applicable employer contribution period that exceeds the cost of your coverage for the current and subsequent coverage quarter.

Precertified services are services that must be coordinated and approved by Empire’s Medical Management or Behavioral Healthcare Management Programs to be covered by the Plan. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

Provider is a hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional health care practitioner under the Empire portion of the Plan. Empire will pay benefits only for covered services within the scope of the practitioner’s license. For behavioral health care purposes, “provider” includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post degree supervised experience in psychotherapy and an additional three years of post licensure supervised experience in psychotherapy. For maternity care purposes, “provider” includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.
Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children in situations involving divorce, legal separation or a paternity dispute.

Quarterly CAPP statement is the report that is mailed to Plan C participants before the start of each coverage quarter for the purpose of electing coverage for that quarter.

Retrospective review is one that is conducted after you receive medical services.

Same-day surgery means same-day, ambulatory or outpatient surgery that does not require an overnight stay in a hospital.

Self-payments are quarterly payments you make toward the cost of your health care coverage if employer contributions to your CAPP account are insufficient for coverage or for the level of coverage you want.

Special enrollment is a Plan provision that allows you to enroll in Plan C under certain circumstances, such as having a baby or losing coverage under another plan.

Spouse refers to a partner to whom you are legally married under state and federal law.

TRICARE is a health care program provided by the government for uniformed service members and their families.

Uncombining CAPP accounts refers to a provision under Plan C that allows two Plan C participants to separate a combined account into two individual accounts.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides rights concerning health care coverage to employees who take a military leave.

Union means the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada.

Urgent precertification is one associated with medical circumstances that require a quick decision.

Year of service is a calendar year in which you were covered under the Health & Welfare Fund for at least six consecutive months.
PLEASE NOTE:
Blue area is 5” High Flap with rounded corner