THE LOCAL 7
TILE INDUSTRY
WELFARE FUND

SUMMARY PLAN
DESCRIPTION/PLAN
DOCUMENT

Effective July 1, 2005

Dear Participant:

We are pleased to provide you with this up-to-date Plan Booklet (Plan Document) summarizing The Local 7 Tile Industry Welfare Fund and describing the benefits available to you and your family under the Plan. This Plan is effective July 1, 2005 and replaces the Plan Documents/ SPDs for the Tile Layers Local 52 Insurance & Welfare Plan, the Tile Workers Union Local No. 77 Welfare Fund Employee Benefit Plan and the Tile Finishers Union Local No. 88, New York Welfare Fund.

You will find in this booklet a description of the benefits to which you and your family are entitled, the Plan eligibility rules and regulations, the procedures you should follow in order to obtain benefits provided by the Plan and information provided to you in accordance with new regulations. We urge you to become familiar with the benefit program and to share this booklet with your family. Please keep it for future reference.

This document describes your benefits under this Welfare Fund. Do not rely on statements made by any individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity. No Employer, union representatives, supervisor, or shop steward is in a position of authority to discuss your rights under this Plan.

The Fund Office is available to help you and your family at all times. If you have any questions, please do not hesitate to call or visit the Fund Office at:

The Local 7 Tile Industry Welfare Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street
New York, NY 10001
(212) 505-5050

Sincerely,

THE BOARD OF TRUSTEES

The Local 7 Tile Industry Welfare Fund

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TABLE OF CONTENTS

VERY IMPORTANT INFORMATION YOU OR YOUR DEPENDENT(S) MUST FURNISH TO THE PLAN 1
CHANGE IN BENEFICIARY 1

DEFINITIONS 2

ELIGIBILITY PROVISIONS 3
- ELIGIBLE EMPLOYEE 3
- DEFINITIONS OF TERMS USED UNDER THE ELIGIBILITY PROVISIONS 3
  - INITIAL ELIGIBILITY FOR ACTIVE PARTICIPANTS 3
  - Plan A 4
  - Plan B 4
- MAINTAINING ELIGIBILITY 4
- INITIAL ELIGIBILITY FOR DEPENDENTS 4
- WHEN COVERAGE ENDS FOR YOU 6
- WHEN COVERAGE ENDS FOR YOUR DEPENDENTS 6
- REINSTATEMENT OF ELIGIBILITY 6
- DISABILITY EXTENSION 6
- EXTENSION OF COVERAGE FOR DEPENDENTS FOLLOWING THE DEATH OF THE EMPLOYEE 7
- CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS 7

ENROLLMENT 8
- INITIAL ENROLLMENT 8
- HOW TO ENROLL 8
- SPECIAL ENROLLMENT 8
- START OF COVERAGE FOLLOWING ENROLLMENT 9
- QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) 9

LEAVES OF ABSENCE 10
- FAMILY AND/OR MEDICAL LEAVE 10
- LEAVE FOR MILITARY DUTY IN THE UNITED STATES ARMED FORCES 10
- REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCES 11

RETIREE ELIGIBILITY PROVISIONS 12
- BENEFITS AVAILABLE FOR RETIRED EMPLOYEES 12
- HEALTH CARE BENEFITS FOR ACTIVE PARTICIPANTS AGE 65 OR OLDER 12
- COBRA ELIGIBILITY (COBRA-QUALIFYING EVENTS) 13
  - For You 13
  - For Your Dependents 13
- HOW COBRA COVERAGE WORKS 14
- PROVIDING NOTICE OF QUALIFYING EVENTS 14
- HOW SHOULD NOTICE BE PROVIDED? 15
- TO WHOM SHOULD THE NOTICE BE SENT? 15
- WHEN SHOULD THE NOTICE BE SENT? 15
- WHO CAN PROVIDE A NOTICE? 15
- HOW TO ELECT COBRA CONTINUATION COVERAGE 16

TABLE OF CONTENTS *continued*

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED 17
DURATION OF COBRA COVERAGE 17
COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY 17
COST OF COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY 18
WHEN A SECOND QUALIFYING EVENT OCCURS DURING AN 18-MONTH COBRA CONTINUATION PERIOD 18
TERMINATION OF EMPLOYMENT/REDUCTION OF HOURS FOLLOWING MEDICARE ENTITLEMENT 19
PAYING FOR COBRA CONTINUATION COVERAGE (THE COST OF COBRA) 19
CONFIRMATION OF COVERAGE BEFORE ELECTION OR PAYMENT OF THE COST OF COBRA CONTINUATION COVERAGE 19
ADDITION OF NEWLY ACQUIRED DEPENDENTS 20
LOSS OF OTHER GROUP HEALTH PLAN COVERAGE 20
WHEN COBRA CONTINUATION COVERAGE MAY BE CUT SHORT 20
NOTICE OF TERMINATION OF COBRA 21
WHOM TO CONTACT IF YOU HAVE QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES (VERY IMPORTANT INFORMATION) 21
FMLA AND COBRA 22
LEAVE OF ABSENCE (LOA) AND COBRA 22
CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS 22
ADDITIONAL COBRA ELECTION PERIOD & TAX CREDIT IN CASES OF ELIGIBILITY FOR BENEFITS UNDER THE TRADE ACT OF 1974 23

OTHER PLAN INFORMATION 24
HOSPITAL LENGTH OF STAY FOR CHILDBIRTH 24
RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY 24

DEATH BENEFITS 25
DEATH BENEFITS 25
BENEFICIARY 25
APPLYING FOR BENEFITS 25

MEDICAL BENEFITS 26
ELIGIBLE MEDICAL EXPENSES 26
NON-ELIGIBLE MEDICAL EXPENSES 26
IN-NETWORK AND OUT-OF-NETWORK BENEFITS 26
DEDUCTIBLE 27
THE MULTIPLAN PPO 27
DIRECTORIES OF NETWORK PROVIDERS 27
MAXIMUM PLAN BENEFITS 28
Annual Plan Maximum Benefits 28
Lifetime Maximum Benefits 28
Maximums That Apply to Specific Eligible Medical Expenses 28

TABLE OF CONTENTS *continued*

REVIEW OF CERTAIN PROCEDURES 29
WHAT SERVICES SHOULD BE PRECERTIFIED (APPROVED BEFORE THEY ARE PROVIDED): 30
HOW TO REQUEST PRECERTIFICATION 30
CONCURRENT (CONTINUED STAY) REVIEW 30
RETROSPECTIVE REVIEW 31
REVIEW OF NEW MEDICAL SERVICES OR SUPPLIES 31
SCHEDULE OF MEDICAL BENEFITS 32

DENTAL EXPENSE BENEFITS 43
ALTERNATIVE PROCEDURES 43
PRE-TREATMENT AUTHORIZATION 43
THE PLAN'S DENTAL PANEL 43
SCHEDULE OF DENTAL BENEFITS 45

VISION CARE 49
BENEFITS 49
Plan A 49
Plan B 49
Retiree 49
HOW TO OBTAIN VISION CARE BENEFITS FROM PARTICIPATING PROVIDERS 49
HOW TO OBTAIN VISION CARE BENEFITS FROM NON-PARTICIPATING PROVIDERS 49
VISION SCREENING 50
THE GENERAL VISION SERVICES (GVS) NETWORK 50
EXCLUSIONS 51

PRESCRIPTION DRUG BENEFITS 52
HOW THE PLAN WORKS 52
Mandatory Maintenance Prescription Drug Program 52
Duane Reade, ... 52
CVS, ... 52
Rite Aid, or 52
Walgreens 52
RETAIL DRUGS 52
Participating Pharmacies 52
Non-Participating Pharmacies 52
MAIL ORDER (HOME DELIVERY) DRUG SERVICE 53
DRUGS THAT ARE COVERED 53

RETIREE BENEFITS 55
HOW THIS BENEFIT WORKS 55
Dental, Optical and Prescription Drug Benefits for All Retirees 55
Medical Benefits for Non-Medicare-Eligible Retirees 55
Medical Benefits for Medicare-Eligible Retirees 55
When You Are Covered by Medicare Advantage Plan 55
When the Plan Participant Is Not Covered by Medicare 56
When the Plan Participant Enters Into a Medicare Private Contract 56
HOSPITAL BENEFITS FOR MEDICARE-ELIGIBLE PENSIONERS 56
MEDICAL BENEFITS FOR MEDICARE-ELIGIBLE PENSIONERS 57

GENERAL EXCLUSIONS (APPLICABLE TO ALL SERVICES AND SUPPLIES) 58

TABLE OF CONTENTS *continued*

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES 62
1. Alternative/Complementary Health Care Services Exclusions 62
2. Behavioral (Mental) Health Care Exclusions 62
3. Blood Donation, Collection or Administration Exclusions 62
4. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions 63
5. Cosmetic Services Exclusions 63
6. Custodial Care Exclusions 63
7. Dental Services Exclusions 64
8. Drugs, Medicines and Nutrition Exclusions 64
9. Durable Medical Equipment Exclusions 65
10. Fertility and Infertility Services Exclusions 65
11. Foot/Hand Care Exclusions 65
12. Genetic Testing and Counseling Exclusions 65
13. Hair Exclusions 66
14. Hearing Care Exclusions 66
15. Home Health Care Exclusions 66
16. Maternity/Family Planning/Contraceptive Exclusions: 66
17. Nursing Care Exclusions 67
18. Prophylactic Surgery or Treatment Exclusions 67
19. Rehabilitation Therapy Exclusions (Inpatient or Outpatient) 67
20. Sexual Dysfunction Services Exclusions 68
21. Sleep Disorders/Snoring/Obstructive Sleep Apnea 68
22. Smoking Cessation or Tobacco Withdrawal Exclusions 68
23. Transplant (Organ and Tissue) Exclusions 68
24. Vision Care Exclusions 69
25. Weight Management and Physical Fitness Exclusions 69

COORDINATION OF BENEFITS 70
HOW DUPLICATE COVERAGE OCCURS 70
COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN 70
When and How Coordination of Benefits (COB) Applies 70
WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES 71
The Overriding Rules 71
Rule 1: Non-Dependent/Dependent 71
Rule 2: Dependent Child Covered Under More Than One Plan 71
Rule 3: Active/Laid-Off or Retired Employee 72
Rule 4: Continuation Coverage 72
Rule 5: Longer/Shorter Length of Coverage 73
HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY: 73
ADMINISTRATION OF COB 74
COORDINATION WITH MEDICARE 75
COORDINATION WITH OTHER GOVERNMENT PROGRAMS 76
WORKERS' COMPENSATION 76

THIRD PARTY LIABILITY 78
A. ADVANCE ON ACCOUNT OF PLAN BENEFITS 78
B. REIMBURSEMENT AND/OR SUBROGATION AGREEMENT 78
C. COOPERATION WITH THE PLAN BY ALL COVERED INDIVIDUALS 78

TABLE OF CONTENTS *continued*

D. SUBROGATION 79
E. REMEDIES AVAILABLE TO THE PLAN 79
F. ARBITRATION 79

CLAIMS AND APPEALS PROCEDURES 80
CLAIMS AND APPEALS PROCEDURES 80
HOW TO FILE A CLAIM 80
WHEN AND WHERE TO FILE CLAIMS 80
Hospital, Medical, Dental and Optical Claims 80
Retail Prescription Claims 81
Death Benefit Claims 81
AUTHORIZED REPRESENTATIVES 81
CLAIMS PR3OCEDURES 81
Pre-Service and Urgent Care Claims 81
Urgent Care Claim 82
Concurrent Claims 83
Post-Service Claim 83
Death Benefit Claims 84
Notice of Decision 85
REQUEST FOR REVIEW OF DENIED CLAIM 85
Review Process 86
Timing of Notice of Decision on Appeal 86
Notice of Decision on Review 87
LIMITATION ON WHEN A LAWSUIT MAY BE STARTED 87

DEFINITIONS 88

IMPORTANT PLAN INFORMATION 105
NAME OF PLAN 105
NAME AND ADDRESS OF PLAN SPONSOR MAINTAINING THE PLAN 105
EMPLOYER IDENTIFICATION NUMBER 105
PLAN NUMBER 105
TYPE OF PLAN 105
TYPE OF ADMINISTRATION AND FUNDING MEDIUM 105
THIRD PARTY ADMINISTRATOR 106
PLAN ADMINISTRATOR 106
AGENT FOR SERVICE OF LEGAL PROCESS 106
PLAN TRUSTEES 106
PLAN YEAR 107
NO LIABILITY FOR THE PRACTICE OF MEDICINE OR DENTISTRY 107
DISCRETIONARY AUTHORITY OF THE TRUSTEES AND THEIR DESIGNEES 107
AMENDMENT OR TERMINATION 107
FACILITY OF PAYMENT 108

HIPAA PRIVACY RULES 109

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 109

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 114

VERY IMPORTANT INFORMATION YOU OR YOUR DEPENDENT(S) MUST FURNISH TO THE PLAN

In addition to information you must furnish in support of any claim for Plan benefits under the Plan, you or your covered Dependents must immediately furnish any information you or they may have that either affects eligibility for coverage under the Plan, or the Fund Office's ability to properly administer your benefits. These events include, but are not limited to:

- change of name;
- change of address (advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage);
- addition of any Dependent by marriage, birth or adoption;
- marriage, divorce, legal separation, or death of yourself or any covered spouse and/or Dependent child;
- any information regarding the status of your Dependent child(ren), including, but not limited to:
    - your Dependent child reaching the Plan's limitation age;
    - the school status of a Dependent child over age 19;
    - the existence of any physical or mental handicap; or
    - the marriage of your Dependent child;
- Medicare enrollment or disenrollment;
- Social Security disability benefits award or termination; and
- The existence of other medical or dental coverage.

Change in Beneficiary

Contact the Fund Office to obtain the necessary form if you wish to change the beneficiary for your Death Benefits. Otherwise, the permanent records may not reflect your current wishes regarding your choice of beneficiary.

Please notify the Fund Office as soon as possible of any changes to the information described above and forward that information in writing to the Fund Office at:

The Local 7 Tile Industry Welfare Fund
Daniel H. Cook Associates
253 West 35th Street
New York, NY 10001

(212) 505-5050

DEFINITIONS

See the Definition section at the end of this document for definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded services.

ELIGIBILITY PROVISIONS

Eligible Employee

Eligibility for benefits from The Local 7 Tile Industry Welfare Fund is based on hours worked under a Collective Bargaining Agreement that obligates Employers to report and pay contributions to this Fund on behalf of employees. You must satisfy certain eligibility requirements, as described in this section, in order to be eligible for benefits under this Plan.

Definitions of Terms Used Under the Eligibility Provisions

- An **Employee** is an individual who is covered by a Collective Bargaining Agreement or Participation Agreement that requires his or her Employer to make contributions to this Fund on his or her behalf. Contributions on an Employee's behalf are made for hours worked in accordance with the applicable Agreement.
- A **Collective Bargaining Agreement** is an agreement between an Employer and the Tile, Marble & Terrazzo Local Union No. 7 that requires the Employer to make contributions to this Fund.
- A **Participation Agreement** is an agreement between the Trustees of this Fund and an Employer.
- **Covered Employment** is work performed under a Collective Bargaining Agreement for which contributions must be paid to this Fund.
- An **Eligible Participant** is an Employee who has satisfied the requirements for eligibility for benefits from this Fund as described in this Plan Booklet and who is currently eligible for benefits. Therefore, Employees who are eligible under the Plan based completely on payment of COBRA premiums and Employees who are eligible because hours are credited during periods of disability are considered Eligible Participants but are not Active Participants.
- An **Active Participant** is an Employee whose eligibility for benefits is based on hours worked for which his/her Employer must make contributions.
- A **Retired Employee** or **Retiree** is an Employee who has qualified for and is receiving Retiree Benefits from this Plan. An Employee is a Retired Employee on the effective date of his Pension, provided he or she meets the requirements described in the "Retiree Eligibility" subsection later in this section.

Initial Eligibility for Active Participants

You are eligible for benefits based on the number of hours you work in Covered Employment during any eighteen (18) consecutive month period. Depending on the number of hours you work, you are eligible for Plan A or Plan B benefits on the first day of the month following the month in which you meet the eligibility requirements as described below.

Plan A

To establish initial eligibility for Plan A coverage, you must work at least 1,500 hours for one or more Contributing Employers during any eighteen (18) consecutive month period. Coverage begins the month following the month in which you have worked at least 1,500 hours during such eighteen (18) month period.

Plan B

To establish initial eligibility for Plan B coverage, you must work at least 900 hours for one or more Contributing Employers during any eighteen (18) consecutive month period. Coverage begins on the month following the month in which you have worked at least 900 hours during such eighteen (18) month period.

Maintaining Eligibility

After establishing initial eligibility for coverage, you will continue to be eligible for coverage during each succeeding Calendar Year (January 1 through December 31), provided that you have worked at least 900 hours (for Plan B coverage) or 1,500 hours (for Plan A coverage) during the previous calendar year.

Initial Eligibility for Dependents

Your Dependents are eligible for Medical, Dental, Prescription Drug and Optical benefits under the Plan.

Your Eligible Dependents include:

1) Your spouse, to whom you are legally married, and
2) Your biological or legally adopted child(ren) or a child placed in your home for adoption for whom you have begun adoption procedures (see the Special Enrollment section for details on this), who are unmarried:
   - Up to the December 31st after he or she turns age 19, or
   - Up to the December 31st after he or she turns age 23, if the Child is a full-time student in an accredited and state licensed technical school or institution of higher education.

Subject to the following provisions:

- The Dependent Child must not provide over one-half of his or her own support for the year.
- The Dependent Child must have the same principal place of abode as the Employee for more than one-half of the year. However, this requirement does not apply if the Dependent child's parents are divorced or separated and the Dependent child is in the custody of one or both parents for more than one-half of the year.
- If the Dependent Child turns age 19 or 24 (if a full-time student) before the end of the calendar year they must not have gross income that is more than the dependency exemption amount ($3,200 in 2005).

A child named in a qualified medical child support order (QMCSO) is also an eligible dependent under this Plan. See the section on QMCSOs for details.

The Plan also covers a Dependent Child who is any age who is permanently and totally disabled (which means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more) provided that:

- The Dependent Child must not provide over one-half of his or her own support for the year, be dependent upon you for lifetime care and supervision and be considered to be handicapped upon reaching age 19.

- The Dependent Child must have the same principal place of abode as the Employee for more than one-half of the year. However, this requirement does not apply if the Dependent Child's parents are divorced or separated and the Dependent Child is in the custody of one or both parents for more than one-half of the year.
- A disabled Dependent Child remains eligible only as long as you are eligible. You must provide the Administrator (Cook) with medical evidence of the child's disability within thirty-one (31) days of the child's 19th birthday.

Notwithstanding the above, a dependent, unmarried child who was on June 1, 2005 between the ages of 19 and 23 and receiving benefits from the Tile Finishers Union Local No. 88, New York Welfare Fund shall continue to receive such benefits from the Local 7 Tile Industry Welfare Fund through the end of the calendar year in which he/she attains age 23 without the requirement that he/she be a full-time student provided that:

- The Dependent Child does not have gross income that is more than the dependency exemption amount ($3,200 in 2005).
- The employee provides over one-half of the Dependent Child's support.
- The Dependent Child has the same principal place of abode as the Employee for more than one-half of the year. However, this requirement does not apply if the Dependent Child's parents are divorced or separated and the Dependent Child is in the custody of one or both of the parents for more than one-half of the year.

When Coverage Ends For You

Coverage will end on the earlier of the following:

- The date the Fund discontinues the group plan;
- The last day of the calendar year for any calendar year in which you fail to work at least 900 hours in Covered Employment; or
- The date you enter the armed services on an active basis for more than 31 days.

When Coverage Ends For Your Dependents

Coverage for your Dependent(s) will end on the earlier of the following:

- When your own coverage ends;
- Six months after the month of the death of the Active Participant;
- The date the Dependent becomes an Active Participant under the Plan;
- The date the Dependent enters the armed services on an active basis for more than 31 days;
- The date the Dependent no longer meets the definition of Dependent; or
- The date that Dependent coverage is discontinued under the Plan.

Coverage ends for your Dependent child on the date the child ceases to meet this Plan's definition of a Dependent child because the child:

- Marries;
- Reaches age 19 (or age 23 for a Dependent child who was receiving benefits from the Local 88 Welfare Fund on June 1, 2005); or
- For your child who is between age 19 and 23, ceases to be a full time student.

Coverage ends for your Spouse on the date you and your Spouse are divorced or legally separated.

When coverage ends for you and/or your Dependents, you may be able to continue coverage for certain benefits under COBRA continuation coverage; see the COBRA section for details.

Reinstatement of Eligibility

Upon termination of eligibility for coverage, you must reestablish eligibility in accordance with the initial eligibility requirements of 900 hours (or 1,500 hours for Plan A coverage) of Covered Employment for one or more Contributing Employer(s) during an eighteen (18) month period.

Disability Extension

If you are an Active Eligible Participant who is temporarily disabled and is receiving State Disability benefits or Workers' Compensation benefits, you will be credited with 35 hours per week for each week of disability for which you are either in receipt of or entitled to State Disability or Workers' Compensation benefits, up to six months, provided such disability began during or immediately after employment with a Contributing Employer. Proof of receipt of either State Disability or Workers' Compensation benefits must be submitted to the Fund Office in order to be credited for such additional hours.

Extension of Coverage for Dependents Following the Death of the Employee

Your Dependents who are eligible for benefits at the time of your death may continue to be covered by the Plan at no cost for 6 months following the month of death. Thereafter, Dependents may elect to purchase COBRA Continuation Coverage for an additional 30 months (for a total of 36 months) from the month following the month of the Active Participant's death.

Certification of Coverage When Coverage Ends

When your coverage ends, you and/or your covered Dependents are entitled by law to, and will be provided with (free of charge), a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. In addition, such a certificate will be provided upon receipt of a written request for such a certificate, if the request is received by the Fund Office within two years after the date coverage ended. See the COBRA section for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

ENROLLMENT

Initial Enrollment

The Fund Office will notify you when you are eligible for coverage under the Plan and send you a *Designation of Beneficiary – Fund Office Record Card*. If your Employer fails to remit the required contributions and you are working in Covered Employment and contributions are required on your behalf, you may still be entitled to coverage, provided you furnish the Fund Office with a copy of your pay stubs indicating that a sufficient number of hours were worked to reach eligibility.

Please note that if you do not enroll yourself and/or your Dependents as described, benefits will not be payable by the Fund. Claims that you submit will be denied and will have to be resubmitted after you have properly enrolled.

How to Enroll

To enroll for benefits provided by the Welfare Fund, you must submit a completed *Designation of Beneficiary – Fund Office Record Card*. To enroll your eligible Dependents for Fund coverage, you need to enroll them when you are enrolled for coverage. You must provide the Fund Office with proof of dependent status. The Fund Office will accept a copy of any of the following documents as proof of dependent status:

- **Marriage:** copy of the certified marriage certificate and a notarized *Affidavit of Spousal Coverage* to notify the Fund of other coverage for your spouse or family.
- **Birth:** copy of the certified birth certificate.
- **Adoption or placement for adoption:** court order signed by a judge.
- **Full-time student status:** Birth certificate (if not already on file) and a copy of current semester official class schedule reflecting full-time student status or signed statement from the Registrar.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically Handicapped (as that term is defined in this document). The Plan may require that you show proof of support and maintenance such as a copy of your income tax return showing you claim the child as a Dependent on IRS tax forms.

Special Enrollment

If you decline enrollment (or do not enroll) your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment and enroll for benefits as described above, after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your Dependents. However, you must request enrollment after the marriage, birth,

adoption, or placement for adoption and complete the proper enrollment paper work, as described above.

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

Start of Coverage Following Enrollment

Coverage for your Dependents cannot begin until the Fund Office receives a completed enrollment form (the *Designation of Beneficiary – Fund Office Record Card*) along with the necessary documentation (e.g., birth certificate, marriage certificate, adoption papers) and the Affidavit of Spousal Coverage. **Once the Fund Office receives a complete enrollment form and the necessary documentation, coverage will be effective retroactive to the date your coverage started or as described below, for newly enrolled Dependents.** If the Fund does not receive the necessary enrollment material (including proof of dependency), claims will be denied and will need to be resubmitted once enrollment is complete.

Your newborn biological child will be covered from the date of birth.

Your adopted Dependent child will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. Newborn adopted children will be covered from the date of birth. 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 placed for adoption with you within 31 days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Coverage for your new spouse begins on the day you marry, provided you properly enroll your spouse.

Qualified Medical Child Support Order (QMCSO)

According to federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office can provide more details about enrolling your children in such cases. A statement that describes the QMCSO procedures is available from the Fund Office at no cost to you. To receive a copy of these procedures, please contact the Fund Office.

LEAVES OF ABSENCE

There are certain circumstances where you may be entitled to a leave of absence from covered employment.

Family and/or Medical Leave

You are entitled by law to up to 12 weeks of unpaid leave under the Family and Medical Leave Act (FMLA), which is for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. The Fund will maintain your eligibility status and keep your medical coverage in effect during that leave period provided your Employer properly grants such leave and made the required

notification to the Fund. If you do not return to work after your FMLA leave ends, you may be required to repay the contributions your Employer paid toward your coverage.

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

- Have worked for a covered 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 a 75 mile radius.

Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your covered Dependents, the same as to active employees and their covered Dependents.

If you do not return to Covered Employment after your leave ends, you are entitled to continue your coverage under the COBRA provision described in the section of this document entitled "Continuation of Coverage."

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the continuation of coverage should be referred to the Fund Office.

Leave for Military Duty in the United States Armed Forces

Under the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994, employers must grant unpaid military leave and continue to subsidize health care coverage for up to 31 days. If you go into military service you can continue your Health coverage during that period for up to 31 days. If you go into active military service for more than 31 days, you should receive military health care coverage at no cost. Your coverage under this Plan will terminate; however, you may continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

➢ If you elect USERRA continuation coverage before December 10, 2004, the maximum period for this coverage is up to 18 months.

➢ If you elect USERRA continuation coverage on or after December 10, 2004, the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See the COBRA section of this document for details. In addition, your Dependent(s) may be eligible for health care coverage under Tricare (formerly know as CHAMPUS). This Plan will coordinate coverage with Tricare.

When you are discharged (not less than honorably) from military duty, your full eligibility will be reinstated on the day you return to work with a Participating Employer, provided you return to work within:

1. 90 days from the date of discharge if the period of service was more than 180 days; or
2. 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by military duty, these time limits are extended for up to 2 years.

Questions regarding your entitlement to this leave should be referred to your Employer.

Questions regarding the continuation coverage during leave should be referred to the Fund Office.

Reinstatement of Coverage after Leaves of Absences

If your coverage ends while you are on an approved FMLA leave or USERRA military service, your coverage will be reinstated on the day you return to active employment (see the Military Leave section above for more details), subject to all annual and lifetime plan benefit maximums that were incurred prior to the leave of absence.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

RETIREE ELIGIBILITY PROVISIONS

In order to be eligible for Retiree Welfare Fund benefits, you must be at least age 62 (or totally disabled and in receipt of a Disability Pension) and you must:

(1) Have been covered by the Welfare Fund for three (3) of the last four (4) years immediately preceding your Retirement; and

(2) Have at least fifteen (15) years of service under the Bricklayers International Pension Fund or the Tile Layers Union Local No. 52, New York Pension Fund.

Benefits Available for Retired Employees

Your Retiree benefits are outlined beginning in the section entitled, “Retiree Benefits”, beginning on page 56. In general, non-Medicare eligible Retired Employees are eligible for medical benefits that are similar to benefits that are provided for Active Participants subject to limits and maximums specific for Retirees. You must be enrolled in Part A of Medicare and maintain coverage for Part B (and pay the applicable Part B premium) when you become eligible for Medicare. **Note: Because this Plan only pays benefits that supplement Medicare for any Medicare-eligible Retirees, failure to enroll in Part A and to elect Medicare Part B coverage (and to pay the applicable premiums) will result in a lower benefits.**

All Retirees are eligible for a Death Benefit of $1,000 as described on page 26. All Retirees are eligible for Prescription Drug benefits that are the same as Active Participants. In addition, all Retirees are eligible for Optical and Dental Benefits but they differ from those available to Active Participants and are described beginning on page 56.

HEALTH CARE BENEFITS FOR ACTIVE PARTICIPANTS AGE 65 OR OLDER

Medicare Participants May Retain or Cancel Coverage Under This Plan

If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you and/or any of your Dependents are covered by both this Plan and by Medicare, as long as you remain actively employed, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA section for further information about COBRA Continuation Coverage. If any of your Dependents are covered by Medicare and you **cancel** that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan because of Medicare eligibility is yours, and yours alone. Neither this Plan nor your Employer will provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan. See the section on "Coordination of Benefits" for more details on how this Plan coordinates with Medicare.

COBRA CONTINUATION OF COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your covered Dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered Dependents may continue the same coverage that you had before the COBRA-Qualifying Event, including:

- Medical coverage
- Hospital coverage
- Prescription drug coverage
- Dental coverage
- Optical coverage.

Death Benefits are not available under COBRA Continuation Coverage.

COBRA Eligibility (COBRA-Qualifying Events)

For You

COBRA coverage is available to you if coverage would otherwise end because:

- You do not work the required number of hours to maintain eligibility under the Welfare Fund.
- Your employment ends for any reason other than gross misconduct.

For Your Dependents

COBRA coverage is available for your covered Dependents if coverage would otherwise end because:

- You do not work the required number of hours to maintain eligibility under the Welfare Fund.
- You (the active participant) end employment for any reason other than gross misconduct.
- You (the active participant) die, get divorced, become legally separated, or become entitled to Medicare (and voluntarily drop Fund coverage due to Medicare entitlement).
- Your Dependent child ceases to be eligible for Fund coverage. For example, he or she marries or reaches the maximum age limit for coverage. See the definition of Dependents on page 4.

How COBRA Coverage Works

The following is the title, address, and telephone number of the person who is responsible for administering COBRA Continuation Coverage for the Fund:

Fund Office
The Local 7 Tile Industry Welfare Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, New York 10001
(212) 505-5051

In order to protect your family's rights, you should keep the Fund office informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Fund office.

Providing Notice of Qualifying Events

Your Employer will usually notify the Fund Office of your death, termination of employment, reduction in hours, retirement, or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification. It is also important that you notify the Fund Office of a COBRA-Qualifying Event in your life or in the life of your spouse and/or Dependent child(ren) so that the Fund Office can provide you and/or them with a COBRA election form and a certificate of creditable coverage.

The time period in which your Employer must notify the Fund Office of your death, termination of employment, reduction in hours, retirement or Medicare entitlement will begin to run from the date of your loss of coverage and not the date of the Qualifying Event.

You and/or a family member are responsible for providing the Fund Office with timely notice of the following Qualifying Events:

(1) The divorce or legal separation of a covered employee from his or her spouse.

(2) A beneficiary ceases to be covered under the Plan as a Dependent child of a participant.

(3) The occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include an employee's death, entitlement to Medicare, divorce or legal separation or child losing Dependent status.

In addition to these Qualifying Events, there are two other situations where you and/or a family member must provide the Fund Office with notice within the timeframe noted in this section:

(4) When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

(5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of these five occurrences listed above. Failure to provide this notice in the form and within the timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

How Should Notice Be Provided?

Notice of any of the five situations listed above must be provided in writing by sending a letter to the Fund Office containing the following information: your name, a description of one of the five events listed above for which you are providing notice, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

To Whom Should the Notice Be Sent?

Notice should be sent to Daniel H. Cook Associates at the address on the prior page.

When Should the Notice Be Sent?

If you are providing notice due to a divorce or legal separation, a Dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than **60 days after the later of** (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event or (2) the date of the qualifying event.

The procedures for providing notice of a Social Security Administration determination of disability or notice of a Social Security Administration determination that you are no longer disabled are described under the section, "Disability Extension – COBRA Coverage in Cases of Social Security Disability".

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a summary plan description or a general (initial) notice by the Plan.

Who can Provide a Notice?

Notice may be provided by the covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the

covered employee or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, his Spouse and Child are all covered by the Plan, and the child ceases to become a Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

If notice has not been received by the Fund Office by the end of the applicable period described above, you and/or your spouse and/or your Dependent(s) will not be entitled to choose/extend COBRA Continuation Coverage.

Once you have provided notice, the Fund Office will send you information about COBRA coverage.

Where you or your Dependents have provided notice to the Fund of a divorce or legal separation, beneficiary ceasing to be covered under the plan as a Dependent, or a second qualifying event but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same timeframe that is required to provide an election notice.

How to Elect COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, or you divorce, or become legally separated, become entitled to Medicare, or when the Fund Administrator is notified that a Dependent Child lost Dependent status under the Plan, the Fund Administrator will give you and/or your covered Dependents notice of the date on which coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to apply for COBRA Continuation Coverage.**

Each qualified beneficiary with respect to a particular Qualifying Event has an independent right to elect COBRA continuation coverage. One or more covered Dependents may elect COBRA even if the employee does not. For example, both the employee and the employee's Spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for minor child(ren). In order to elect COBRA Continuation Coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS AFTER RECEIVING NOTICE, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

If you notified the Fund Office of a Qualifying Event and you are not entitled to COBRA coverage, the Fund Administrator will send you a written notice stating the reason you are no longer eligible for COBRA. The Fund will provide this notice to you within 14 days after its receipt of your notice of a Qualifying Event.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health

coverage under the Plan to end, but you must pay for it. See the section on "Paying for COBRA Continuation Coverage" that appears later in this section for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Duration of COBRA Coverage

Your COBRA coverage can continue for up to 18, 29 or 36 months, depending on the COBRA-Qualifying Event. The COBRA continuation coverage period begins on the date you and/or your covered Dependents lose coverage (rather than on the date of the Qualifying Event).

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length Of COBRA Coverage:
You and Your Eligible Dependents	• Your employment ends (for example, you resign). • Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's program.	18 months (29 months if you and your eligible Dependents are Social Security-disabled*)
Your Eligible Dependents Only	• You die; • You are divorced or legally separated; • You become entitled to Medicare and voluntarily drop Fund coverage); • Your child(ren) no longer qualifies as an eligible Dependent under the Plan	• 36 months

- *See "COBRA Coverage In Cases of Social Security Disability," below for more details.*

COBRA Coverage in Cases of Social Security Disability

If you, your spouse or any of your covered Dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to an additional 11 months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the

first 60 days of COBRA coverage;

- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration; and
- The Fund is notified by you or your eligible Dependent that the determination was received:
  - no later than 60 days after it was received; and
  - before the 18-month COBRA continuation period ended.

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

- 30 days after Social Security has determined that you and/or your eligible Dependent(s) are no longer disabled;
- the end of the 29-month period from the date of the loss of coverage due to the COBRA-Qualifying Event;
- the date the disabled individual becomes entitled to Medicare; or
- the day after your COBRA payment is due and not timely paid (including grace periods).

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA continuation coverage is extended because of Social Security Disability, the Fund will charge members and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of Social Security disability). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying

event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Termination of Employment/Reduction of Hours Following Medicare Entitlement

If you become entitled to (enrolled in) Medicare and you later have a termination of employment or reduction of hours, then your spouse and/or your Dependent child(ren) would be entitled to COBRA Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of hours or 36 months from the date you became entitled to Medicare, whichever is longer.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated employees and families (including both the Employer's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay for the COBRA Continuation Coverage after it is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. **If payments are not made by the end of this grace period, COBRA Continuation Coverage will be terminated.**

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect or you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, notice will be given to the Health Care Provider that COBRA has not yet been elected, and/or the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will be provided retroactively to the date coverage was lost if you elect COBRA continuation coverage.

Addition of Newly Acquired Dependents

If, while you (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you

for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you properly enroll them after the marriage, birth, adoption, or placement for adoption. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, notify the Fund Administrator within 31 days after acquiring the new Dependent. Adding a Spouse or Dependent Child may require that you switch from individual to family coverage and may cause an increase in the amount you must pay for COBRA Continuation Coverage.

If COBRA coverage ceases for you, your spouse or your Dependent child(ren) before the end of the maximum 18, 29 or 36-month COBRA period, COBRA coverage will also end for the newly added Dependent. Check with the Fund for more details on how long COBRA coverage lasts.

Loss of Other Group Health Plan Coverage

If, while you (the Employee) are enrolled for COBRA Continuation Coverage your spouse or Dependent loses coverage under another group health plan, you may enroll the spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under the pre-COBRA plan and declined, the spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may require that you switch from individual to family coverage and may cause an increase in the amount you must pay for COBRA Continuation Coverage.

When COBRA Continuation Coverage May Be Cut Short

Once COBRA Continuation Coverage has been elected, it may be cut short on the occurrence of any of the following events:

1. The date on which the Fund no longer provides group health coverage to any participants;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to (enrolled in) Medicare (usually 65);
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the covered person may have;
5. The date the plan has determined that the covered person must be terminated

from the plan for cause;

6. If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed to be no longer disabled.

If any covered person enrolls in Medicare, the COBRA Continuation Coverage of that person ends, but the COBRA Continuation Coverage of any covered spouse or Dependent child of that covered person will not be affected.

Notice of Termination of COBRA

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

Whom to Contact if You Have Questions or To Give Notice of Changes in Your Circumstances (Very Important Information)

If you have any questions about your COBRA rights, please contact the Fund Office at the address listed on page 14.

Also, remember that to avoid loss of any of your rights to obtain COBRA Continuation Coverage, you must notify the Fund Office:

1. within 60 days if you have changed marital status; or have a new Dependent child; or
2. within 60 days of the date you or a covered Dependent spouse or child has been determined to be totally and permanently disabled by the Social Security Administration; or
3. within 60 days if a covered child ceases to be a "Dependent child" as that term is defined by the Plan; or
4. promptly if you or your spouse have changed your address.

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

FMLA and COBRA

Taking a leave under the Family and Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur after the FMLA period expires, if the person does not return to work and thus loses coverage under their group health plan. Then the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Employee notifies the Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA

If an Employee is offered alternative health care coverage while on LOA, and this alternate coverage is not identical in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required under this Plan.

Certification of Coverage when Coverage Ends

When your COBRA coverage ends, the Fund Office will provide you and/or your covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan (including if applicable, COBRA coverage). If, within 63 days after your coverage under this Plan ends, (including if applicable, COBRA coverage) you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan (including if applicable, COBRA coverage), and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after this Plan knows, or has reason know, that your (or their) coverage (including, if applicable, COBRA coverage) under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated.

In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the Fund Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the Fund Administrator whose address is listed below.

Please make all requests for certificates of creditable coverage to:

Fund Office
The Local 7 Tile Industry Welfare Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, New York 10003-1599

(212) 505-5051

ADDITIONAL COBRA ELECTION PERIOD & TAX CREDIT IN CASES OF ELIGIBILITY FOR BENEFITS UNDER THE TRADE ACT OF 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your Dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/. The Fund Office may also be able to assist you with your questions.

OTHER PLAN INFORMATION

Hospital Length of Stay for Childbirth

This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Physician or other health care Provider to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care Provider or Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

Reconstructive Services and Breast Reconstruction After Mastectomy

This Plan complies with the **Women's Health and Cancer Rights Act** that requires that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage is provided for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Coverage for the mastectomy related service or benefits will be subject to the same Maximum Plan Benefits provisions that apply with respect to other medical or surgical benefits provided under the Plan.

Consult the Schedule of Medical Benefits section of this document for coverage details about maternity and post-mastectomy breast reconstructive benefits.

DEATH BENEFITS

In the event of the death of an Active Participant or Retired Employee, a death benefit will be paid to the named beneficiary.

DEATH BENEFITS

	Benefit
Active Participants	$10,000
Retired Employees	$1,000

(plus $100 per year of service up to 10 years for a maximum benefit of $2,000)

Your Death benefit is administered by Daniel H. Cook Associates. This benefit will be paid to any beneficiary you name if you die from any cause. You may change your beneficiary at any time and as often as desired, provided you follow the procedure described below. Payment of any amount of Term Life Insurance benefits may be made in installments. Details about this option may be obtained from the Fund Office.

BENEFICIARY

Your beneficiary is a person you choose to receive any benefit payable as a result of your death. In order to name or change a beneficiary, obtain a Designation of Beneficiary Card from the Fund Office. The change will be effective when the Fund Office receives the updated *Designation of Beneficiary Card*. You do not need consent of your beneficiary to make a change. Your beneficiary may be changed at any time.

If you name more than one beneficiary, they will share equally in the benefit unless you indicate otherwise.

If the named beneficiary (ies) dies before you, or you have not named a beneficiary at the time of your death, the amount will be paid to the following: (a) your spouse, or if your spouse is not living; (b) to your child(ren), or if no living children survive you; (c) your parents in equal shares or to the one surviving parent, or if neither parent has survived you; (d) to your estate.

APPLYING FOR BENEFITS

Beneficiaries can submit a claim for the Death Benefit by contacting the Fund Office. Completed claims forms should be forwarded to the Fund Office along with proof of death (i.e., death certificate).

Death Benefits cannot be assigned. Any attempt by the beneficiary to assign benefits will be considered null and void.

The Fund's medical coverage provides benefits for Medically Necessary Eligible Medical Expenses either on an In-Network or Out-of-Network basis. Your out-of-pocket expenses differ, depending on whether you use an In-Network provider or an Out-of-Network provider, as described below and outlined in the Schedule of Medical Benefits beginning on page 34.

The Plan reimburses Eligible Medical Expenses up to the Plan's Allowance. In general, the Plan's Allowance is based on the MultiPlan Negotiated Rate. If you wish to obtain the allowance for a particular service or supply, contact the Fund Office.

Eligible Medical Expenses

You are covered for expenses you incur for "eligible medical expenses," which are limited to those that are:

1. determined by the Plan Administrator or its designee to be "Medically Necessary," but only to the extent that the charges are within the negotiated rate; and
2. not services or supplies that are excluded from coverage (as provided in the Exclusions section of this document); and
3. not services or supplies in excess of the Lifetime Maximum or Annual Maximum described in this Booklet.

You should note that the Plan might not reimburse you for all expenses that are considered Eligible Medical Expenses.

Non-Eligible Medical Expenses

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are determined to be not Medically Necessary, in excess of the Negotiated Rate, not covered by the Plan, in excess of the Lifetime Maximum and/or in excess of any applicable Annual Maximum.

In-Network and Out-of-Network Benefits

You may obtain health care services from In-Network or Out-of-Network Health Care Providers.

- **In-Network:** The MultiPlan PPO offers you a choice of participating providers. In-Network health care providers have agreements with MulitPlan under which they provide health care services and supplies for favorable negotiated discounted fees for Plan Participants. If you receive medical services or supplies from a health care Provider that has contracted with the Plan's PPO, you will be responsible for paying less money out of your pocket. Health care Providers who are under a contract with the PPO have agreed to accept the discounted amount (MultiPlan's Negotiated Rate) the Plan pays for covered services as payment in full.
- **Out-of-Network (also called Non-Network):** This refers to providers who have not contracted with the PPO Network. Out-of-Network providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies that they provide. These Out-of-Network Providers **may bill you a non-discounted amount** for any balance that may be due **in addition**

to the allowed amount (according to the Negotiated Rate) payable by the Plan, also called balance billing. When you choose to receive care from an Out-of-Network provider, the Plan generally reimburses Eligible Medical Expenses at 100% of the Negotiated Rate after the *Deductible* (as described below). As a result, when you use an Out-of-Network provider, you are responsible for the Deductible (as described below), AND any charges over and above the MultiPlan Negotiated Rate (e.g., providers may balance bill you).

Deductible

Each calendar year, if you or an eligible Dependent use an Out-of-Network Provider, you must first satisfy the Deductible before the Plan will pay any benefits. The individual Deductible is $100 per person and $300 per family per calendar year. Once you (and your Dependents) have satisfied the Deductible, the Plan will usually reimburse Eligible Medical Expenses at 100% of the Negotiated Rate, as described above. Deductibles are applied to Eligible Medical Expenses in the order in which claims are received by the Plan on a calendar year basis. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductible and non-eligible expenses will not count towards the Deductible.

The MultiPlan PPO

The MultiPlan PPO covers physician visits, x-ray, laboratory and diagnostic tests, hospitalization and home health care, among other things. *The Schedule of Medical Benefits* beginning on page 34 summarizes the In-Network and Out-of-Network benefits available to you through the PPO, as well as any limitations or maximums that may apply to individual benefits.

The MultiPlan network consists of more than 390,000 primary care practioners and specialists throughout the New York and New Jersey region. This network of physicians covers specialists ranging from internists and other family doctors to various types of surgeons. Additionally, MultiPlan's networks include hospitals, diagnostic facilities, laboratory facilities and radiology facilities, as well as ancillary providers.

Directories of Network Providers

Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any provider is a member of MultiPlan, by visiting www.MultiPlan.com or by calling 1-800-546-3887.

Maximum Plan Benefits

Annual Plan Maximum Benefits

For each covered person, the maximum amount payable for Eligible Medical and Hospital Expenses under the Plan will not exceed $250,000 per covered individual per calendar year for all benefits payable by the Plan (except for Dental and Optical benefits) during that year.

Lifetime Maximum Benefits

The Plan's overall Lifetime Maximum is $1,000,000. Plan coverage will not exceed $1,000,000 per person per lifetime.

These maximums apply to the entire period an individual is covered under this Plan (as a Participant and a Retiree) and any previous plan(s) including coverage

under the Tile Layers Local 52 Insurance & Welfare Fund, the Tile Workers Union Local No. 77 Welfare Fund Employee Benefit Plan and the Tile Finishers Union Local No. 88, New York Welfare Fund. All amounts payable under those plans will accumulate toward this maximum.

Maximums That Apply to Specific Eligible Medical Expenses

In addition, benefits for certain Eligible Medical Expenses are subject to annual or lifetime maximums. Once the Plan has paid the annual or lifetime maximum for a Plan benefit, it will not pay any further benefits for those services or supplies under that provision of the Plan for the balance of the calendar year. The services or supplies that are subject to the annual or lifetime maximums are identified in the *Schedule of Medical Benefits*. Any lifetime maximums for specific benefits apply to the entire period an individual is covered under this Plan and any previous plan(s) including coverage under the Tile Layers Local 52 Insurance & Welfare Fund, the Tile Workers Union Local No. 77 Welfare Fund Employee Benefit Plan and the Tile Finishers Union Local No. 88, New York Welfare Fund.

REVIEW OF CERTAIN PROCEDURES

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Plan to afford the cost of maintaining your benefits.

To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a Review Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Plan is better able to afford to maintain the Plan and all its benefits. If you follow the procedures, you may avoid some out-of-pocket costs. However, if you do not follow these procedures, you may be responsible for paying more out of your own pocket.

You should note that the fact that your Physician recommends surgery, inpatient hospitalization or that your Physician or other health care Provider proposes or provides any other medical services or supplies does not mean that the recommended services or supplies will be considered Medically Necessary for determining coverage under the Medical Plan or that it is not specifically excluded or limited under the Plan.

The Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The certification that a service is Medically Necessary does not mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan in either whole or in part.

All treatment decisions rest with you and your Physician (or other health care Provider). You should follow whatever course of treatment you and your Physician (or other health care Provider) believe to be the most appropriate, even if the Plan does not certify a proposed surgery or other proposed medical treatment as

Medically Necessary or specifically excludes it. Benefits payable by the Plan may, however, be affected by the determination of the review.

With respect to the administration of this Plan, the Claims Administrator (Daniel H. Cook Associates) does not engage in the practice of medicine, and does not assume responsibility for the quality of health care services actually provided, even if they have been certified by the Claims Administrator as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified as Medically Necessary.

Precertification Review is a procedure, administered by the Claims Administrator (Daniel H. Cook Associates) to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a hospital or health care facility, surgery, and other health care services are Medically Necessary.

What Services Should Be Precertified (Approved Before They Are Provided):

- All Elective Hospital admissions. Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section;
- All Elective admissions to a Skilled Nursing Facility or Subacute facility.
- All Elective Surgery regardless of where it is to be performed.
- All inpatient admissions for Rehabilitation and/or other Therapy.
- All Home Health Care (including Home Infusion Services).
- Diagnostic tests (such as MRI, CT scans, etc.), that are estimated to cost $1,000 or more.
- Durable Medical Equipment.
- Treatment for any rehabilitation or therapy that is covered according to the Schedule of Medical benefits that will exceed ten (10) outpatient visits. Your physician must submit a treatment plan to the Fund Office for review in order to receive benefits for therapy or rehabilitation for the additional 20 visits covered under the Plan.
- High-risk Pregnancies

How to Request Precertification

You or your Physician should call the Claims Administrator at 1-877-888-AUTH (2884) Monday through Friday, between the hours of 9 AM and 5 PM. Calls for Elective services should be made at least 7 days before the expected date of service, where possible. If you call after hours, leave a message and someone will get back to you (or the Provider) the next business day.

You or the caller should be prepared to provide all of the following information: the Plan name, Participant's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other health care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies. If additional information is needed, you will be advised.

If your admission or service is determined not to be Medically Necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claims and Appeals Procedures section regarding appealing the determination.

Concurrent (Continued Stay) Review

When you are receiving medical services in a hospital or other inpatient health care facility, the Claims Administrator will monitor your stay by contacting the utilization review department within the facility or your physician to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your physician or other health care providers of various options and alternatives for your medical care available under this Plan.

If at any point your stay is found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay was not Medically Necessary or if it is determined that the care provided was related to an excluded service under the Plan, no benefits will be paid on any related hospital, medical or surgical expense.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the Claims Administrator before you are admitted. If this happens, you should notify them of the hospital admission within 48 hours (or by the next business day, if later). You, your physician, the utilization review department, the hospital, a family member or friend can make the phone call. This will enable the Plan to assist with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care Providers of the various recommendations, options, and alternatives for your medical care.

Retrospective Review

All claims for medical services or supplies that have not been reviewed under the Plan's Precertification or Concurrent (Continued Stay) Review, may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Administrator receives a determination from a designated medical review firm that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies** You have the right to appeal an adverse determination. For complete information on Claim Review and Claim Appeals, see the Claims and Appeals section of this document.

Review of New Medical Services or Supplies

New medical services, supplies, and medications are implemented frequently. If you or your Provider presents a new medical service, supply or medication (that has a temporary code assigned for the new, non-experimental, non-investigational

procedures) which it is not currently maintained on the Fund's Negotiated Rate schedule for reimbursement (or for precertification), the Claims Administrator will review the service, supply or medication to determine if the treatment is Medically Necessary, not Experimental and not otherwise excluded under the Plan. If the Claims Administrator determines it is eligible for reimbursement, they will determine a rate of reimbursement based on internal protocols, which include a review of the service, supply or medication against current medical practice and current reimbursement rates for similar types of procedures. The review and determination will be at the discretion of the Plan Administrator or its designee. You may contact Daniel H. Cook Associates for more information.

Schedule of Medical Benefits

The chart outlines the schedule for medical services, supplies, and conditions that are considered Eligible Medical Expenses and are covered by the Plan.

Except as otherwise noted in this section or in the Exclusions section which begins on page 59, Eligible Medical Expenses are the Plan's Allowances for services listed below and that are incurred by you or an eligible Dependent - subject to the Definitions, Limitations and Exclusions and all other provisions of this document. Services and supplies must be approved by a Physician (or other health care Provider as defined in the definition section), must be Medically Necessary (as defined on pages 97-98), and not excluded by the Plan.

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Hospital Services ***Inpatient*** • Room and board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic/ services and pathological examinations. • Newborn care. • Use of cardiographic or endoscopic equipment and supplies. • Related Medically Necessary ancillary services. • Drugs and medicines for use in the hospital and commercially available for purchase. • Use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee. • Sera, biological, vaccines, and intravenous preparations. • Anesthesia supplies and use of anesthesia equipment. • Dressings and plaster casts. • Oxygen and other inhalation therapeutic and rehabilitation services and supplies. ***Outpatient Benefits*** ▪ Ambulatory surgical facility (surgicenter, same day surgery). ▪ Outpatient department of a hospital.	Private room is covered only if Medically Necessary. Benefits will be paid at the semi-private rate.	***Plan A-*** 100% of Negotiated Rate up to the 120th Day After 120th day - 80 days at 50% of Negotiated Rate ***Plan B*** – 100% of the Negotiated Rate up the 90th day (90 days covered in full) After the 90th day, 80 days at 50% of the Negotiated Rate In-Network and Out-of-Network benefits combined.	

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
<u>Physician and Other Health Care Providers</u> Benefits are payable when provided by a Physician or other covered health care Provider for: ➢ Office visits ➢ Consultations ➢ Home Physician services ➢ In-Hospital (including Emergency room).	See the definition of Physician and health care Provider in the Definitions section.	100% of the Negotiated Rate	100% of the Negotiated Rate after Deductible
<u>Surgery</u> Benefits are payable when performed by a Physician or Surgeon in an office, hospital, emergency room or other covered health care facility location.	• The surgery must be performed, recommended and approved by a legally qualified physician or surgeon. • If two or more surgeries are performed through the same incision, the total benefits paid for all such operations will not exceed the maximum Negotiated Rate for the operation for which the largest benefit is payable.	100% of the Negotiated Rate	100% of the Negotiated Rate after deductible
<u>Anesthesia</u> Benefits are payable if surgery benefits are payable by the Plan.	Benefits are only provided if the anesthesia is administered by a Physician or other health care Provider other than the operating surgeon or an employee of the hospital.	100% of the Negotiated Rate	100% of the Negotiated Rate after Deductible

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This chart explains benefits payable by the Plan.</th></tr>
<tr><th colspan="2"></th><th colspan="2">Reimbursement Level</th></tr>
<tr><th>Benefit Description</th><th>Explanations and Limitations</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td><u>Allergy Services</u>

• Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast.

• Desensitization and hyposensitization (allergy shots given at periodic intervals).

• Allergy antigen solution.</td><td>▪ Allergy services are covered only when ordered by a Physician.

▪ Payable up to $1,500 per covered person per calendar year; In-network and Out-of-network benefits combined.</td><td>Payable at 100% of the Negotiated Rate</td><td>Payable at 100% of the Negotiated Rate after Deductible</td></tr>
<tr><td><u>Ambulance Services</u>

Ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency.</td><td>Expenses for ambulance services are covered only when those services are for an Emergency as that term is defined in the Definitions section of this document under the heading of “Emergency (Medical)”.</td><td>100% of the Negotiate Rate</td><td>100% of the Negotiated Rate after the Deductible</td></tr>
<tr><td><u>Annual Physical</u>
Well child Visits

Adult Annual Physicals</td><td>Includes Outpatient newborn and well child visits and routine childhood immunizations (e.g. DPT, Polio, MMR, HIB, hepatitis, chicken pox, and tetanus). Other immunizations for children at high risk are covered.

Includes:
• Routine preventive physical exam.
• Screenings as indicated by age.
• Adult immunizations.
• For Women - gynecology exam, pap test and mammogram (annually after age 40).</td><td colspan="2">100% of Negotiated Rate to $500 per covered individual per calendar year</td></tr>
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SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Behavioral (Mental) Health Benefits (See page 43 for Substance Abuse benefits)	▪ See the specific exclusions related to Behavioral (Mental) Health Benefits, including mental retardation and learning disability, in the Exclusions section. ▪ Benefits are payable only for services rendered by health care Providers listed in the Definitions section.	Inpatient – 15 days per covered individual per calendar year (In-network and out-of network benefits combined) Outpatient – 26 visits per year payable at the Negotiated Rate	Inpatient 15 days per covered individual per calendar year (In-network and out-of network benefits combined) Outpatient – $10 allowance per visit 100% of the Negotiated Rate after Deductible
Chemotherapy	Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, and Physician's office or at home.	Benefit payments vary by location in which the service is performed. See the applicable section for reimbursement levels.	
Chiropractic Services	➢ Payable up to $2,000 per covered individual per lifetime. In-Network and Out-of-Network benefits combined. ➢ The maximum applies to all services and supplies payable in conjunction with the chiropractic services including x-rays and laboratory expenses.	100% of the Negotiate Rate	100% of the Negotiate Rate after Deductible
Dialysis Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• In the home, the Plan pays the cost of appropriate and necessary supplies required for home dialysis treatment as well as the cost of reasonable rental of required equipment. • In the hospital or free-standing facility, the Plan pays the cost of necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.	Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. See the applicable section for details.	

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
<u>Durable Medical Equipment (DME)</u> Coverage is provided for: • **Rental** (but only up to the allowed purchase price of the Durable Medical Equipment) of wheel chair, hospital bed, oxygen and equipment for its administration; • **Purchase of standard models** at the option of the Plan; • **Repair, adjustment or servicing** or Medically Necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired; • Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration. **<u>Nondurable Supplies</u>** • Surgical dressing, casts, splints, trusses, braces, crutches • Coverage is provided for up to a 31-day supply of: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions section. To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions section. • Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician. • To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions section.	100% of Negotiated Rate (Deductible applies for Out-of-network benefits) The Annual Maximum Plan Benefit for Durable Medical Equipment, Nondurable Supplies and Corrective Appliances is $2,500 per covered person per calendar year for In-network and Out-of-network benefits combined	

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<tr><th>Benefit Description</th><th>Explanations and Limitations</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td><u>Corrective Appliances</u>
<u>(Prosthetic & Orthotic Devices, other than Dental)</u>
• Subject to the limitations and Overall and Annual Maximum Plan Benefits shown in the Explanations and Limitations column, coverage is provided for Medically Necessary:
  • rental (but only up to the allowed purchase price of the device).
  • Purchase of standard models at the option of the Plan.
  • repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person’s physical condition or if the device cannot be satisfactorily repaired.
  • Artificial limbs and eyes
  • Colostomy or ostomy supplies.
  • Prescribed custom orthotics devices.</td><td>• See the exclusions related to Corrective Appliances in the Exclusions section. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of “Prosthetics” and “Orthotics” in the Definitions section.

• Corrective Appliances are covered only when ordered by a Physician or health care Provider.</td><td colspan="2">The annual maximum Plan benefit for Corrective Appliances is $2,500 per covered person per calendar year for In-Network and Out-of-Network benefits combined. This maximum is combined with DME and Non-DME benefits, as described on the pervious page.</td></tr>
<tr><td><u>Emergency Room & Urgent Care Services</u>
• Hospital emergency room (ER) for a medical Emergency.
• Use of an Urgent Care facility.
• Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit.
• (See also the Ambulance section of this schedule.)</td><td>➢ See definition of Emergency in the Definition section of this booklet
➢ If services are determined not to be for the care of an Emergency, as defined in this Booklet, the benefit will be paid at the same rate as a regular office visit and you may be responsible for the balance of the bill.</td><td>100% of the Negotiated Rate</td><td>100% of the Negotiated Rate after Deductible</td></tr>
</table>

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Home Health Care Services include: • Part-time professional nursing (skilled nursing care only). • Part-time home health aide services (up to 4 hours of care is equal to one home care visit). • Medical supplies, drugs and medicines prescribed by a physician. • Laboratory services. • Home infusion services in connection with Home Health Care, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column	• Home Health Care services are covered only when ordered by a Physician or health care Provider and provided by a non-profit New York State Certified Home Health Agency. • Benefits are provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required and they are pre-authorized under the Plan's Review procedures. • Benefits are limited to 50 visits per covered person per calendar year. • Benefits for home infusion therapy are covered only if the above applies and only to a maximum of $10,000 per covered person per calendar year. Any prescription drugs used in connection with home infusion therapy must be obtained through Sun Rx or from a MultiPlan In-Network provider. No benefits are payable if received from an out-of-network or not through Sun Rx. • See the exclusions related to Home Health Care and Custodial Care (including personal care and childcare) in the Exclusions section of this document.	100% of the Negotiated Rate	100% of the Negotiated Rate after the Deductible
Hospice Benefits Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the classification for Hospice, as defined in this Booklet.		100% of the Negotiated Rate	100% of the Negotiated Rate after the Deductible up to $2,500 per person per lifetime.

SCHEDULE OF MEDICAL BENEFITS

This chart explains benefits payable by the Plan.

		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Maternity Services • Hospital charges and Physician fees for Medically Necessary maternity services.	• See the Eligibility section on how to enroll a Newborn Dependent Child(ren). • Pregnancies that are considered high-risk should be reviewed according to the Plan's Review Procedures. • Pregnancy-related care is covered for a female employee or spouse only.	Benefit payments vary by Provider who provides the service or supply. See the applicable section for reimbursement levels.	
Pain Management Benefits are payable for steroid epidural injections for pain management.	• Covered twice annually up to $2,000 per covered person per calendar year. • In-Network and Out-of-Network benefits combined.	100% of Negotiated Rate	100% of the Negotiated Rate after Deductible
Preadmission Testing (Outpatient) • Laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery in that hospital.		100% of Negotiated Rate	100% of the Negotiated Rate after Deductible

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Radiology (X-Ray), Laboratory, Nuclear Medicine and Radiation, Therapy Services (outpatient) • X-ray and Laboratory examinations. • X-ray and radium treatments with other radioactive substances. • Technical and professional fees associated with diagnostic and curative services, including radiation therapy.	• Covered only when ordered by a Physician or health care Provider. • Covered under Hospital services if necessary for the diagnosis and treatment of the condition for which you are hospitalized.	Payable at 100% of the Negotiated Rate	Payable at 100% of the Negotiated Rate after Deductible
Rehabilitation Services ***Cardiac and Pulmonary - Outpatient*** • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • **Pulmonary Rehabilitation** is available to those individuals with a chronic respiratory disorder who are able to actively participate in a Pulmonary Rehabilitation program which is likely to improve their respiratory condition, as determined by the Plan Administrator or its designee.	• Outpatient Cardiac and Pulmonary Rehabilitation are provided for up to 36 visits per covered person per calendar year. • All services must be ordered by a physician and reviewed according to the Plan's Review procedures.	100% of the Negotiated Rate	100% of the Negotiated Rate after Deductible

SCHEDULE OF MEDICAL BENEFITS This chart explains benefits payable by the Plan.			
		Reimbursement Level	
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network**
Substance Abuse Benefits	Benefits are payable for services for treatment of acute medical and/or psychiatric illness resulting from alcohol or substance abuse, on an inpatient or outpatient basis in an accredited non-governmental facility.	$10,000 lifetime maximum (Out-of-network and In-network benefits combined benefits) Inpatient - Subject to the same limits for inpatient Hospital benefits Outpatient - Payable in the same manner as other outpatient benefits.	
Surgical Sterilization	Benefits are payable for Vasectomy, tubial ligation or tubal coagulation.	Varies by location and service; see the applicable section for benefit payment level.	
Therapy ***Occupational, Physical and Speech Therapy (Physical Medicine and Rehabilitation)*** Short term active, progressive Occupational, Physical, or Speech Therapy performed by licensed or duly qualified therapists as ordered by a Physician. Maintenance Rehabilitation and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Exclusions section.	• Maximum of 30 outpatient visits/inpatient days are covered per covered individual per calendar year. In-network and out-of-network benefits are combined. This 30 visit/day maximum includes both outpatient visits and inpatient days. • Inpatient Rehabilitation Services are only covered if provided in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** when such services are performed under a program approved by the New York State Department of Health or similar state agency for hospitals outside New York State.	Benefit payments vary by the Provider who provides the service or supply. See the applicable section for reimbursement levels.	

DENTAL EXPENSE BENEFITS

The Welfare Fund provides dental benefits on a self-insured basis as follows:

For Plan A Participants, benefits are payable up to the Plan's allowance (as described in the following Schedule of Dental Benefits) to a maximum of $3,000 per covered individual per calendar year.

For Plan B Participants, benefits are payable up to the Plan's allowance (as described in the following Schedule of Dental Benefits) to a maximum of $2,000 per covered individual per calendar year.

For Retirees, benefit are payable up to the Plan's allowance (as described in the following Schedule of Dental Benefits) to a maximum of $800 per covered individual per calendar year.

An Orthodontic Benefit (once per lifetime) is available for eligible children – paid up to the 19th birthday only (as defined in this schedule).

Alternative Procedures

Often there are several ways to treat a particular dental problem that will produce a satisfactory result. The Plan will pay benefits based on the procedure that meets the least expensive professionally acceptable standards of dental practice as determined by Daniel H. Cook Associates. You may choose a more costly procedure. However, if you do, you will be responsible for paying the difference between the charges for the more costly procedure and the benefits paid by the Plan. All treatment decisions rest with you and your Dentist. The pretreatment authorization procedure described below will help you know what benefits the Plan will pay. You will then be able to determine the difference (if any) that you may have to pay yourself.

Pre-treatment Authorization

Whenever you expect that your dental expenses for a course of treatment will be more than $1,000 and/or for any crown or bridgework, you must obtain Pre-Treatment Authorization. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain authorization, you and your Dentist should complete the regular dental claim form, available from and to be sent to Daniel H. Cook Associates, Inc. indicating the type of work to be performed along with pertinent x-rays and the estimated cost (valid for a 120-day period). Once it is received, Cook will review the form and send you and your Dentist (within 30 days) a statement showing what the Plan will pay. Your Dentist may call Cook at 212-505-5050 for a prompt determination of the benefits payable for a particular dental procedure.

The Plan's Dental Panel

The Plan has contracted with a panel of dentists and dental hygienists that have agreed to accept the Plan's Schedule of Dental Benefits as payment in full. If you use a non-panel dentist, the provider will balance bill you the difference between the Plan's fee schedule and the actual charges. You will be provided with a list of participating providers when you become eligible for Plan benefits. You also may contact the Fund Office for a listing of participating providers.

SCHEDULE OF DENTAL BENEFITS

ADA Code	Description	Plan's Allowance
0120	Periodic Oral Evaluation (only 2 regular exams 0120 and/or 0150 combined per plan yr)	$30.00
0140	Limited Oral Evaluation – problem focused (2x per plan yr)	35.00
0150	Comprehensive Oral Examination (only 2 regular exams 0120 and/or 0150 combined per plan yr)	45.00
0210	Intraoral - complete series - incl. bitewings (1x per 3 plan yrs)	80.00
0220	Intraoral, Periapical, first film	10.00
0230	Intraoral, Periapical, each additional film	8.00
0240	Intraoral, Occlusal film (2x per 3 plan yrs)	20.00
0270	Bitewings, single film (4x per plan yr)	10.00
0272	Bitewings, two films (2x per plan yr)	15.00
0274	Bitewings, four films (1x per plan yr)	30.00
0320	Temporomandibular joint arthrogram (1x per plan yr.)	40.00
0330	Panoramic film (1x per 3 plan yrs)	60.00
0340	Cephalometric film (1x per plan yr)	50.00
0460	Pulp vitality test (1x per plan yr)	30.00
0470	Diagnostic casts (1x per patient lifetime)	35.00
1110	Prophylaxis - Adult (2x per plan yr)	55.00
1120	Prophylaxis – child to age 12 (2x per plan yr)	40.00
1203	Topical application of fluoride excl. prophy - child (2x per plan yr)	20.00
1204	Topical application of fluoride excl. prophy - adult (2x per plan yr)	20.00
1351	Sealant - per tooth (2x per patient lifetime)	30.00
1510	Space Maintainer - fixed – unilateral (1x per patient lifetime)	150.00
1550	Re-cementation of space maintainer (1x per patient lifetime)	25.00
2140	Amalgam - 1 surface, primary/permanent (1x per plan yr)	50.00
2150	Amalgam - 2 surfaces, primary/permanent (1x per plan yr)	65.00
2160	Amalgam - 3 surfaces, primary/permanent (1x per plan yr)	80.00
2161	Amalgam - 4+ surfaces, primary/permanent (1x per plan yr)	100.00
2330	Resin based composite - 1 surface, anterior (1x per plan yr)	65.00
2331	Resin based composite - 2 surfaces, anterior (1x per plan yr)	80.00
2332	Resin based composite - 3 surfaces, anterior (1x per plan yr)	100.00
2335	Resin based composite - 4+ surfaces or involving incisal angle, anterior (1x per plan yr)	125.00
2391	Resin based composite - 1 surface, posterior (1x per plan yr)	50.00
2392	Resin based composite - 2 surfaces, posterior (1x per plan yr)	65.00
2393	Resin based composite - 3 surfaces, posterior (1x per plan yr)	80.00
2394	Resin based composite - 4 surfaces, posterior (1x per plan yr)	100.00
2620	Inlay - porcelain/ceramic - 2 surfaces* (1x per 5 plan yrs)	275.00
2630	Inlay - porcelain/ceramic - 3+ surfaces* (1x per 5 plan yrs)	325.00

ADA Code	Description	Plan's Allowance
2642	Onlay - porcelain/ceramic- 2 surfaces* (1x per 5 plan yrs)	325.00
2720	Crown - resin w/high noble metal* (1x per 5 plan yrs)	250.00
2721	Crown - resin w/base metal* (1x per 5 plan yrs)	250.00
2722	Crown - resin w/noble metal* (1x per 5 plan yrs)	250.00
2750	Crown - porcelain fused to high noble metal* (1x per 5 plan yrs)	500.00
2751	Crown - porcelain fused to base metal* (1x per 5 plan yrs)	500.00
2752	Crown - porcelain fused to noble metal* (1x per 5 plan yrs)	500.00
2780	Crown - cast high noble metal* (1x per 5 plan yrs)	400.00
2781	Crown - cast base metal* (1x per 5 plan yrs)	400.00
2782	Crown - cast noble metal* (1x per 5 plan yrs)	400.00
2790	Crown - full cast high noble metal* (1x per 5 plan yrs)	450.00
2791	Crown - full cast base metal* (1x per 5 plan yrs)	450.00
2792	Crown - full cast noble metal* (1x per 5 plan yrs)	450.00
2910	Recement inlay (1x per plan yr)	35.00
2920	Recement crown (1x per plan yr)	35.00
2930	Prefab stainless steel crown - primary (1x per plan yr)	150.00
2931	Prefab stainless steel crown - permanent* (1x per 5 plan yrs)	150.00
2940	Sedative filling (1x per patient lifetime)	40.00
2952	Cast post and core in addition to crown* (1x per 5 plan yrs)	225.00
2953	Each add'l cast post - same tooth* (1x per 5 plan yrs)	150.00
2954	Prefab post and core in addition to crown* (1x per 5 plan yrs)	175.00
3230	Pulpal therapy (resorbable filling) - anterior, primary	80.00
3240	Pulpal therapy (resorbable filling) - posterior, primary	100.00
3310	Anterior RCT (excl. final restoration) (1x per patient lifetime)	350.00
3320	Bicuspid RCT (excl. final restoration) (1x per patient lifetime)	425.00
3330	Molar RCT (excl. final restoration) (1x per patient lifetime)	500.00
3346	Retreatment of previous RCT - anterior (1x per patient lifetime)	350.00
3347	Retreatment of previous RCT - bicuspid (1x per patient lifetime)	425.00
3348	Retreatment of previous RCT - molar (1x per patient lifetime)	500.00
3410	Apicoectomy/Periradicular surgery – anterior (1x per patient lifetime)	325.00
3421	Apicoectomy/Periradicular surgery - bicuspid (1x per patient lifetime)	375.00

SCHEDULE OF DENTAL BENEFITS continued

ADA Code	Description	Plan's Allowance
3425	Apicoectomy/Periradicular surgery - molar (1x per patient lifetime)	425.00
3426	Apicoectomy/Periradicular surgery (each additional root) (1x per patient lifetime)	150.00
3430	Retrograde Filling - per root (1x per patient lifetime)	90.00
4240	Gingival flap procedure, incl. root planing - 4+ teeth per quad	275.00
4241	Gingival flap procedure, incl. root planing - 1-3 teeth per quad	125.00
4249	Clinical crown lengthening - hard tissue (1x per 4 plan yrs)	250.00
4260	Osseous Surgery - 4+ teeth per quad (1x per 4 plan yrs)	450.00
4261	Osseous Graft - 1-3 teeth per quad (1x per 4 plan yrs)	300.00
4263	Bone replacement graft - 1st site in quad (1x per 4 plan yrs)	250.00
4264	Bone replacement graft - ea. add'l site in quad (1x per 4 plan yrs)	200.00
4266	Guided tissue regeneration - resorbable barrier, per site	200.00
4270	Pedicle soft tissue graft procedure (1x per 4 plan yrs)	350.00
4271	Free soft tissue graft procedure (1x per 4 plan yrs)	300.00
4341	Perio scaling & root planing - 4+ teeth per quad (1x per 4 plan yrs)	75.00
4342	Perio scaling & root planing - 1-3 teeth per quad (1x per 4 plan yrs)	50.00
4355	Full mouth debridement to enable evaluation (1x per plan year)	75.00
4381	Localized delivery of chemotherapeutic agents	20.00
4910	Perio maintenance procedure (2x per plan yr)	80.00
5110	Complete denture - maxillary* (1x per 5 plan yrs)	800.00
5120	Complete denture - mandibular* (1x per 5 plan yrs)	800.00
5130	Immediate denture - maxillary * (1x per 5 plan yrs)	800.00
5140	Immediate denture - mandibular * (1x per 5 plan yrs)	800.00
5211	Maxillary partial denture - resin base* (1x per 5 plan yrs)	800.00
5212	Mandibular partial denture - resin base* (1x per 5 plan yrs)	800.00
5213	Maxillary partial denture - metal w/resin* (1x per 5 plan yrs)	800.00
5214	Mandibular partial denture - metal w/resin* (1x per 5 plan yrs)	800.00
5281	Removable unilateral partial denture - 1 piece cast metal* (1x per 5 plan yrs)	500.00
5510	Repair broken complete denture base (1x per plan yr)	125.00
5520	Replace missing or broken teeth (1x per plan yr)	100.00
5610	Repair resin denture base (1x per plan yr)	85.00
5620	Repair cast framework (1x per plan yr)	75.00
5630	Repair or replace broken clasp (1x per plan yr)	75.00
5640	Replace broken teeth - per tooth (1x per plan yr)	85.00

ADA Code	Description	Plan's Allowance
5650	Add tooth to existing partial denture (1x per patient lifetime)	100.00
5660	Add clasp to existing partial denture (1x per patient lifetime)	75.00
5750	Reline complete maxillary denture (lab) (1x per 3 plan yrs)	200.00
5751	Reline complete mandibular denture (lab) (1x per 3 plan yrs)	200.00
5760	Reline maxillary partial denture (lab)	200.00
5761	Reline mandibular partial denture (lab)	200.00
6210	Pontic - cast high noble metal* (1x per 5 plan yrs)	450.00
6211	Pontic - cast base metal* (1x per 5 plan yrs)	450.00
6212	Pontic - cast noble metal* (1x per 5 plan yrs)	450.00
6240	Pontic - porcelain fused to high noble metal* (1x per 5 plan yrs)	500.00
6241	Pontic - porcelain fused to base metal* (1x per 5 plan yrs)	500.00
6242	Pontic - porcelain fused to noble metal* (1x per 5 plan yrs)	500.00
6250	Pontic - resin with high noble metal* (1x per 5 plan yrs)	450.00
6251	Pontic - resin with base metal* (1x per 5 plan yrs)	450.00
6252	Pontic - resin with noble metal* (1x per 5 plan yrs)	450.00
6545	Retainer - cast metal for resin bonded fixed prosthesis* (1x per 5 plan yrs)	200.00
6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis* (1x per 5 plan yrs)	100.00
6600	Inlay - porcelain/ceramic, 2 surfaces* (1x per 5 plan yrs)	275.00
6601	Inlay - porcelain/ceramic, 3+ surfaces* (1x per 5 plan yrs)	325.00
6602	Inlay - cast high noble metal, 2 surfaces* (1x per 5 plan yrs)	300.00
6603	Inlay - cast high noble metal, 3+ surfaces* (1x per 5 plan yrs)	350.00
6604	Inlay - cast base metal, 2 surfaces* (1x per 5 plan yrs)	275.00
6605	Inlay - cast base metal, 3+ surfaces* (1x per 5 plan yrs)	325.00
6606	Inlay - cast noble metal, 2 surfaces* (1x per 5 plan yrs)	325.00
6607	Inlay - cast noble metal, 3+ surfaces* (1x per 5 plan yrs)	375.00
6608	Onlay - porcelain/ceramic, 2 surfaces* (1x per 5 plan yrs)	325.00
6609	Onlay - porcelain/ceramic, 3+ surfaces* (1x per 5 plan yrs)	375.00
6610	Onlay - cast high noble metal, 2 surfaces* (1x per 5 plan yrs)	325.00
6611	Onlay - cast high noble metal, 3+ surfaces* (1x per 5 plan yrs)	375.00
6612	Onlay - cast base metal, 2 surfaces* (1x per 5 plan yrs)	275.00
6613	Onlay - cast base metal, 3+ surfaces* (1x per 5 plan yrs)	325.00
6614	Onlay - cast noble metal, 2 surfaces* (1x per 5 plan yrs)	325.00
6615	Onlay - cast noble metal, 3+ surfaces* (1x per 5 plan yrs)	375.00
6750	Crown - porcelain fused to high noble metal* (1x per 5 plan yrs)	500.00
6751	Crown - porcelain fused to base metal* (1x per 5 plan yrs)	500.00
6752	Crown - porcelain fused to noble metal* (1x per 5 plan yrs)	500.00

ADA Code	Description	Plan's Allowance
6780	Crown - 3/4 cast high noble metal*(1x per 5 plan yrs)	400.00
6781	Crown - 3/4 cast base metal* (1x per 5 plan yrs)	400.00
6782	Crown - 3/4 cast noble metal* (1x per 5 plan yrs)	400.00
6790	Crown - full cast high noble metal* (1x per 5 plan yrs)	450.00
6791	Crown - full cast base metal* (1x per 5 plan yrs)	450.00
6792	Crown - full cast noble metal* (1x per 5 plan yrs)	450.00
6930	Recement fixed partial denture (1x per plan yr)	50.00
6970	Cast post & core in addition to fixed partial denture retainer* (1x per 5 plan yrs)	225.00
6972	Prefab post & core in addition to fixed partial denture retainer* (1x per 5 plan yrs)	175.00
7111	Extraction, coronal remnants – deciduous tooth (1x per patient lifetime)	60.00
7140	Extraction, erupted tooth or exposed root (1x per patient lifetime)	80.00
7210	Surgical removal of erupted tooth (1x per patient lifetime)	150.00
7220	Remove impacted tooth - soft tissue (1x per patient lifetime)	200.00
7230	Remove impacted tooth - partially bony (1x per patient lifetime)	275.00
7240	Remove impacted tooth - completely bony (1x per patient lifetime)	350.00
7241	Removal of impacted tooth - completely bony w/unusual surgical complications (1x per patient lifetime)	400.00
7250	Surgical removal of residual tooth (cutting procedure) (1x per patient lifetime)	125.00
7280	Surgical access of an unerupted tooth (1x per patient lifetime)	250.00
7281	Surgical exposure of impacted/unerupted tooth to aid eruption (1x per patient lifetime)	250.00
7285	Biopsy of oral tissue – hard (1x per plan yr)	250.00
7286	Biopsy of oral tissue – soft (1x per plan yr)	250.00
7310	Alveoloplasty in conjunction with extractions - per quad (1x per patient lifetime)	100.00
7320	Alveoloplasty without extractions - per quad (1x per 5 plan yrs)	175.00
7410	Excision of benign lesion up to 1.25 cm	200.00
7411	Excision of benign lesion > 1.25 cm	250.00
7450	Removal of benign odontogenic cyst/tumor up to 1.25 cm	70.00
7451	Removal of benign odontogenic cyst/tumor > 1.25 cm	125.00
7460	Removal of benign nonodontogenic cyst/tumor up to 1.25 cm	70.00
7461	Removal of benign nonodontogenic cyst/tumor > 1.25 cm	125.00
7510	Incision & drainage of abscess (1x per plan yr)	125.00
8080	Comprehensive orthodontic treatment of the adolescent dentition**	

ADA Code	Description	Plan's Allowance
	(Either code 8080 or 8090 will be paid 1x per patient lifetime)	900.00
8090	Comprehensive orthodontic treatment of the adult dentition** (Either code 8080 or 8090 will be paid 1x per patient lifetime)	900.00
8220	Fixed appliance therapy** (1x per patient lifetime)	250.00
8660	Pre-orthodontic treatment visit** (1x per patient lifetime)	125.00
8670	Periodic othodontic treatment visit** (24 visits per patient lifetime)	125.00
8680	Orthodontic retention -removal of appliances, construction & placement of retainer(s)** (1x ea. top & bottom per patient lifetime)	250.00
8692	Replacement of lost or broken retainer** (1x per patient lifetime)	175.00
9110	Palliative treatment (12x per patient lifetime)	50.00
9220	General anesthesia, first 30 minutes	175.00
9221	General anesthesia - each add'l 15 minutes	90.00
9241	Intravenous conscious sedation/analgesia – first 30 minutes	150.00
9242	Intravenous conscious sedation/analgesia – each add'l 15 minutes	75.00
9310	Professional consultation (2x per plan yr)	50.00
9940	Occlusal guard (1x per patient lifetime)	250.00
9951	Occlusal adjustment – limited (1x per 4 plan yrs)	75.00
9952	Occlusal adjustment – complete (1x per 4 plan yrs)	175.00

No benefits are payable for Cosmetic procedures.

VISION CARE

The Local 7 Tile Industry Welfare Fund provides you and each of your Dependents, who are enrolled for coverage, with a certain level of vision care benefits, depending on whether you are in Plan A, Plan B or a Retiree. The vision care benefits are self-funded and are provided through two networks of providers: Vision Screening (for providers in New Jersey and Florida) and General Vision Services LLC (for providers in New York). You may use either of these networks or go out-of-network to a non-participating provider.

Benefits

Plan A

If you are eligible for Plan A benefits, you and your Dependents are each entitled to two (2) annual vouchers that include an eye exam by a licensed Optometrist, frames and lenses covered in full if you use an optical provider that participates in the Fund's participating panel of providers. If you choose to use a non-panel provider, you and your Dependents are each entitled to reimbursement of $350 toward eye exams, frames and lenses or contact lenses per calendar year.

Plan B

If you are eligible for Plan B benefits, you and your Dependents are each entitled to one (1) annual voucher that includes an eye exam by a licensed Optometrist, frames and lenses covered in full if you use an optical provider that participates in the Fund's participating panel of providers. If you choose to use a non-panel provider, you and your Dependents are each entitled to reimbursement of $200 toward eye exams, frames and lenses or contact lenses per calendar year.

Retiree

Retired Employees are eligible for a vision care allowance of $100 (for non-participating providers) per calendar year per individual.

How To Obtain Vision Care Benefits From Participating Providers

1. Call or write to the Fund Office to request a vision voucher.
2. The Fund Office will mail you a vision voucher. You must use the voucher within ninety (90) days from the date it is issued.
3. Sign the vision voucher when you receive it.
4. Present the voucher to any of the Participating Providers.

How To Obtain Vision Care Benefits From Non-Participating Providers

When you go to a non-participating Vision provider, you must pay the bill and then submit your expenses to the Fund Office. Reimbursement will come from the Fund Office.

Vision Screening

When you go to a participating Vision Screening provider in New Jersey or Florida, you will receive the following services:

- An eye exam,
- Any single vision lenses (including glass, plastic, any prescription, oversize, cosmetic or sun tint),

- Any bifocal or trifocal lenses (including glass, plastic, any prescription oversize, cosmetic or sun tint),
- Any blended (invisible) bifocal,
- Ultraviolet coating,
- Scratch-resistant coating, and
- Any frame in Vision Screening store retailing up to $200.00 for Plan A and Plan B participants ($125 for Retiree).

You should obtain each of the following during the same visit:

A comprehensive eye examination, which (among other items) includes general case history, visual field screening and glaucoma testing, and items 1 or 2 below:

1. (a) A selection of one contemporary eyeglass frame up to a retail value of $200 (Retiree $125) in various styles, sizes and colors, and

   (b) A selection of any one prescription plastic lens, which includes single vision, bifocal, blended bifocal, trifocal, safety, oversize, cataract, polycarbonate lenses, and progressive multi-focal lenses, and

   (c) Cosmetic tinting, prescription sun-glass tints (where the chosen glasses are sunglasses), ultra-violet coating, scratch resistant coating and reflection free coating.
2. A set of standard hard or soft daily wear contact lenses and extended wear contact lenses, including all B&L Spherical lenses. Basic Spherical Disposable Contact Lenses will be covered for the first six months supply. The balance will be offered at a special discount rate. This benefit includes one year of unlimited follow-up visits.

There will be an additional surcharge for Antireflective Coating.

The General Vision Services (GVS) Network

To receive in-network benefits in New York, you should use a GVS provider. You may obtain a list of GVS service centers, Member Offices and Cohen's Fashion Optical locations, free of charge, by calling 1-800-Vision1 or by contacting the Fund Office.

Exclusions

The Plan does not provide for colored contact lenses.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefit is provided by the Fund and administered by SUNRx.

How The Plan Works

As proof of eligibility for benefits, SUNRx will send you a plastic identification card. Each member of your family will be listed on your card. Call the Fund Office to request a new identification card if you do not receive one when you are first eligible for benefits or if you lose yours.

Mandatory Maintenance Prescription Drug Program

The Plan allows for one thirty (30) day supply and one (1) refill of maintenance medication at the local pharmacy. All other refills for maintenance drugs must be obtained via the mail order program or through one of the following maintenance retail chain pharmacies:

Duane Reade,
CVS,
Rite Aid, or
Walgreens.

Retail Drugs

Participating Pharmacies

When you or a Dependent need to have a prescription filled, go to a SUNRx participating pharmacy and show the pharmacist your card. After the pharmacist has filled the prescription, you will be asked to sign the form and pay the applicable copayment for each new or refill prescription.

SUNRx only pays the cost of generic drugs (if one exists). Therefore, if your doctor has prescribed a brand name drug for a prescription drug for which a generic equivalent exists, you will have to pay the difference between the price of the generic drug and the brand name drug in addition to a $10 copayment. The Fund has authorized SUNRx to pay for the cost of the generic equivalent of the brand name drug regardless of whether you go to a participating pharmacy or not. *Tell your doctor that your drug Plan will only pay the cost of generic drugs when he or she is prescribing your medication in order to assure you receive the maximum reimbursement.*

Non-Participating Pharmacies

If you go to a non-participating pharmacy (non SUNRx), you may still be reimbursed for prescription drugs. However, you have to pay for the prescription when it is filled. Mail the pharmacy receipt along with a note indicating your name and social security number to SunRx at the address on the next page.

After the claim is processed, the Fund Office will mail you a reimbursement check based on the reimbursement allowance made to participating pharmacies (which is the average wholesale price (AWP) less any applicable copayment). <u>In addition, if a generic equivalent is available for a brand name drug you purchased, the reimbursement will be based on what the Plan would reimburse you for the generic drug</u>. In other words, if the cost of your prescription is more than SUNRx would reimburse a participating pharmacist, you will not be reimbursed for the difference.

Mail Order (Home Delivery) Drug Service

The mail order service is the easiest and least expensive way to obtain many medications. It is also the most convenient service because the medications are mailed directly to your home. You may use the mail order service to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note that not all medicines are available via mail order. Check with SUNRx for further information.

To use the mail order service

a) Have your doctor write the prescription for a 90-day supply with three (3) refills.

b) Mail your prescription, copayment, and the mail order form to SUNRx, 6 Executive Campus, Suite 400, Cherry Hill, NJ 08002. Mail order forms may be obtained from the Fund Office or SUNRx by calling Member Services at 1-800-786-1791.

c) Your prescription will be processed in two (2) business days and mailed to the address you indicate on the mail order envelope.

If you need help with any of the above information, you may call Member Services at 1-800-786-1791.

Drugs That Are Covered

The Fund's prescription drug benefit only covers medications that, by federal law or state law, require a prescription and are prescribed by a licensed practitioner. In addition, the Plan covers syringes and needles for use in conjunction with insulin injections.

Items That Are Not Covered

- Allergy Serums
- Anabolic Steriods
- Children's Vitamins
- Cosmetic Medications
- Diaphragms
- Genetically Engineered drugs
- Growth Hormone Therapy
- Imitrex auto injector
- Imitrex vial
- Injectable Contraceptive
- Injectables
- Ostomy products
- Rhogam
- Rogaine
- Smoking cessation
- Unauthorized refills
- Yohimbine
- Medications for which you do not need a prescription (except insulin), over the counter drugs,

- Weight control or anorexiants (e.g., Meridia, Xenical),
- Devices or appliances, support garments or other non-medical substances,
- Syringes or needles,
- Investigational or Experimental drugs,
- Oral contraceptives unless Medically Necessary,
- Infertility drugs,
- Medications that treat erectile dysfunction (e.g, Viagra, Levitra),
- Over the counter medications,
- Vitamins, even if they require a prescription,
- Food supplements, including baby formulas,
- Prescriptions covered without charge under federal, state or local programs including Workers' Compensation,
- Immunization agents, biological sera, blood or plasma, and
- Medication for eligible members and dependents who are confined to a rest home, nursing home, sanitorium, extended care facility, hospital, or similar institution.

RETIREE BENEFITS

HOW THIS BENEFIT WORKS

Dental, Optical and Prescription Drug Benefits for All Retirees

Dental benefits are the same as those for Active Participants except that benefits are payable up to a maximum of $800 per calendar year. Vision benefits are the same as those for Active Participants up to a maximum of $100 per calendar year. Prescription drug benefits are the same as those benefits provided for Active Participants.

Medical Benefits for Non-Medicare-Eligible Retirees

If you are a retiree and under age 65 and not otherwise eligible for Medicare Part A or B, your Medical benefits are the same as those for Active Participants.

Medical Benefits for Medicare-Eligible Retirees

If you are over age 65 and/or eligible for Medicare, this Plan supplements Medicare benefits. This section provides a brief description of how Medicare works and how this Plan coordinates with Medicare.

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

Medicare has two parts, A and B. In general, Part A covers hospital services, skilled nursing facilities, hospice and some home health care services. Part B covers medical services such as physician visits, physical and occupational therapy and diagnostic testing. In general, your Retiree coverage supplements Part A and covers the deductibles, and coinsurance amounts. The Plan also supplements Part B coverage and covers the Part B deductible and coinsurance. Medicare does not cover prescription drug, dental, or optical expenses.

When You Are Covered by Medicare Advantage Plan

This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If you are covered by a Medicare Advantage plan and you obtain medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage plan requires it, this Plan will reimburse all applicable copayments or the Medicare allowable amount and will pay the same benefits provided for active Employees less any amounts paid by the Medicare Advantage plan.

However, if you do not comply with the rules of the Medicare Advantage plan, including without limitation, approved referral, preauthorization, case management or utilization of in-network provider requirements, this Plan will NOT provide any health care services or supply or pay any benefits for any services or supplies that you receive.

When the Plan Participant Is Not Covered by Medicare

If you are **eligible for, but are not enrolled in Medicare**, this Plan pays benefits as if it were coordinating with Medicare. Therefore, you will only receive the benefits the Plan would have paid had Medicare paid benefits first (generally the applicable Medicare deductible or coinsurance for a particular service or supply).

When the Plan Participant Enters Into a Medicare Private Contract

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

Hospital Benefits For Medicare-Eligible Pensioners

For any inpatient stay in a short-term general hospital which does not begin during an already existing period of illness, you are entitled to the following to supplement Medicare Part A benefits:

Medicare Benefits	**For each day during a period of illness that you receive inpatient benefits under Part A of Medicare for services provided in a participating hospital or a non-participating hospital, the Plan pays:**
Medicare covers 60 days of inpatient hospital care per period of illness, subject to an initial deductible.	Either (i) amount of the inpatient hospital deductible as determined under Medicare, or (ii) the hospital's regular charges for the hospital service rendered, whichever is less.
Medicare covers 61-90 days of inpatient hospital benefits per period of illness subject to a per day coinsurance amount.	The coinsurance amount as determined by Medicare.
For the 91-150th days of inpatient hospital benefits, you have a 60-day lifetime reserve of additional benefit days provided by Part A of Medicare, subject to a per day coinsurance amount.	The coinsurance amount as determined by Medicare.
Medicare covers the first 20 days of inpatient care in a Skilled Nursing facility in full. For days 21-100, you are subject to a per day coinsurance.	The coinsurance amount for the 21st-100th day.

Medical Benefits For Medicare-Eligible Pensioners

Under Part B of Medicare, you are entitled to medical services that include physician visits, diagnostic x-ray and laboratory and durable medical equipment subject to an annual deductible and coinsurance, which is generally 20% of the Medicare allowance.

In general, the Plan will reimburse you the Medicare Part B deductible and the 20% Medicare coinsurance, based on what Medicare allows. If Medicare excludes a benefit, the Plan will not consider it for payment.

See the "Coordination of Benefits" section of the booklet for details on coordination with Medicare.

PLAN EXCLUSIONS

The following is a list of services and supplies or expenses not covered by the Medical Plan. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first, followed by specific medically-related plan exclusion.

GENERAL EXCLUSIONS (applicable to all services and supplies)

1. Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees and/or photocopying fees.
3. Educational Services: Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an injury, illness or disability of a Covered Individual.
4. Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your employer, or if benefits are otherwise provided under this Plan or any other plan that your employer contributes to or otherwise sponsors, such as HMOs.
5. Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation, Annual Maximum, or Lifetime Maximum Plan benefits as described in the Medical Expense Coverage section of this document.
6. Expenses Exceeding the Plan's Negotiated Rate: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Negotiated Rate as defined in this document.

7. Expenses for Eye refraction, fitting of glasses or hearing aids except as provided under the Vision care benefit.
8. Expenses for elective services, except as explicitly provided by the Plan.
9. Expenses for which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. See the provisions relating to Third Party Liability in the section on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
10. Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.
11. Experimental and/or Investigational Services: Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions section of this document.
12. Failure to Comply with Medically Appropriate Treatment: Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
13. Government-Provided Services (Tricare, VA, etc.): Expenses for services when benefits for them are provided to the Covered Individual under any plan or program (including, without limitation, Tricare, and Veterans programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
14. Hospital stays: Hospital stays or any part of hospital stays that are primarily for diagnostic studies. Hospital benefits that are for services of a physician or private or special nurse or other private attendants or their board.
15. Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of a felony or an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
16. Internet/Virtual Office Visit: Expenses related to an online internet consultation with a Physician or other Health Care Provider, also called a virtual office visit/consultation, physician-patient web service or

physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

17. Leaving a Hospital Contrary to Medical Advice: Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician.
18. Medical Students, Interns or Residents: Expenses for the services of a medical student, intern or resident.
19. Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary, as defined in the Definitions section of this document.
20. Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, electric recliners, special furniture, etc.
21. No-Cost Services: Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
22. No Physician Prescription: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Nurse Practitioner.
23. Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.
24. Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.
25. Operation of a Vehicle Under Influence of Alcohol or Drugs: As determined by the Plan Administrator or its designee, expenses that were incurred by any covered individual for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of an underlying physical or mental health condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect

to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the motor vehicle accident.

26. Personal Comfort Items: Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
27. Physical Examinations, Tests for Employment, School, etc.: Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party; includes exams or drug testing required for employment purposes.
28. Private Room in a Hospital or Health Care Facility: The use of a private room in a Hospital or other health care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
29. Relatives Providing Services: Expenses for services provided by any Physician or other Health care Provider who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
30. Self-Inflicted Injury or Attempted Suicide: Expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted injury or illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.
31. Stand-By Physicians or Health Care Providers: Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Provider was available to do so on a stand-by basis.
32. Telephone Calls: Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual; consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.
33. Travel Contrary to Medical Advice: Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
34. War or Similar Event: Expenses incurred as a result of an injury or illness

due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

1. Alternative/Complementary Health Care Services Exclusions

A. Expenses for acupuncture and/or acupressure

B. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

C. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.

D. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.

2. Behavioral (Mental) Health Care Exclusions

A. Expenses for residential care services for Mental Health care, except as provided and described in the Schedule of Medical Benefits.

B. Expenses for Behavioral Health Care services related to:

i. dyslexia, learning disorders, vocational disabilities;

ii. autism, developmental disabilities, or mental retardation;

iv. court-ordered Behavioral Health Care services or custody counseling;

v. family planning/pregnancy/adoption counseling, transsexual/gender reassignment/sex counseling.

vi. tests and related expenses to determine the presence of or degree of a person's attention deficit disorder, dyslexia or learning disorder.

3. Blood Donation, Collection or Administration Exclusions

Expenses for donation, collection, or administration of autologous blood, blood products, or biological serum.

4. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

A. Expenses for any items that are not Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions section of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.

B. Expenses for replacement of lost, missing, or stolen, duplicate or personalized Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.

C. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment.

D. Expenses for occupational therapy supplies and devices needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.

E. Expenses for nondurable supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

5. Cosmetic Services Exclusions

Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, reduction mammaplasty (breast reduction surgery) or blepharoplasty (eyelift surgery) even if Medically Necessary, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan does cover Medically Necessary Reconstructive Services as required under the Women's Health and Cancer Rights Act (WHCRA) as described on page 25. To determine the extent of this coverage, contact Daniel H. Cook Associates.

6. Custodial Care Exclusions

A. Expenses for Custodial Care as defined in the Definitions section of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.

B. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are not considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are not covered, even if they are Medically Necessary.

7. Dental Services Exclusions

A. Expenses for Dental Prosthetics or Dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body.

B. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) Dysfunction or Syndrome, as that condition is defined in the Definitions section of this document.

C. Expenses for Orthognathic services/surgery for treatment of Prognathism, Retrognathism and TMJ and other cosmetic reasons.

D. Expenses for oral surgery to remove teeth including wisdom teeth, gingivectomies, treatment of dental abscesses, root canal (endodontic) therapy.

8. ***Drugs, Medicines and Nutrition Exclusions***

In addition to those benefits excluded under the Prescription drug benefit, the Plan excludes expenses for:

A. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization, and prenatal vitamins or minerals requiring a prescription.

   Medical foods are generally excluded by the Plan. However, Medical foods (defined in the Definition section of this document) are payable for persons with inherited metabolic disorders to a maximum of $5,000 per person per calendar year subject to the following provisions, as determined by the Plan Administrator or their designee:

   i. Must be prescribed by a Physician to treat a diagnosis of "inherited metabolic disorder" (as that term is defined in this Plan).

   ii. The patient must require specially processed or treated medical foods that must be consumed throughout his or her life, without which the patient may suffer serious mental or physical impairment.

   iii. The patient must be under the regular supervision of a Physician to monitor the inherited metabolic disorder.

   Documentation to substantiate the presence of an inherited metabolic disorder and that the products purchased are medical foods may be required before the Plan will reimburse the participant for costs associated with this benefit.

B. Vaccinations, immunizations, inoculations or preventative injections, except those provided under the Annual Physical benefit for children and/or adults and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).

C. Outpatient prescription drugs are only covered when received through the Prescription Drug Benefits administered by SunRx as described in this Booklet, subject to the definitions, exclusions and limitations described in that section.

9. ***Durable Medical Equipment Exclusions***

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

10. ***Fertility and Infertility Services Exclusions***

Expenses for the diagnosis and treatment of infertility, along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures unless the treatment is

necessary to correct an organic disease.

11. Foot/Hand Care Exclusions

Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation) or hand care including manicure and skin conditioning. Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

12. Genetic Testing and Counseling Exclusions

A. Genetic Testing: Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics except:

Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder but only when those tests are performed using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women.

B. Genetic Counseling: Expenses for genetic counseling.

13. Hair Exclusions

Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

14. Hearing Care Exclusions

A. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including, implantable hearing devices such as cochlear implants.

B. Special education and associated costs in conjunction with sign language education for a patient or family members.

15. Home Health Care Exclusions

A. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies.

B. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient’s home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.

C. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan’s Hospice coverage.

16. Maternity/Family Planning/Contraceptive Exclusions:

A. Contraception: Expenses related to prevention of pregnancy, including, but not limited to drugs or medicines such as birth control pills, emergency contraceptive medication, injectables such as Depo-Provera and Lunelle, contraceptive devices such as condoms, intra-uterine device (IUD) or diaphragm or implantable birth control devices.

B. Termination of Pregnancy: Expenses for elective induced abortion unless the attending physician certifies that the physical health of the woman would be endangered if the fetus were carried to term.

C. Home Delivery: Expenses for pre-planned home delivery.

D. Expenses for childbirth education, Lamaze classes, breast-feeding classes.

E. Services of alternative birthing facilities.

F. Circumcision: Expenses for routine circumcision of newborn males and any complications thereof, except that circumcision of a male more than 10 weeks old is covered if it is determined to be Medically Necessary.

G. Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child or surrogate mother's pregnancy.

H. Expenses related to cryostorage of umbilical cord blood or other tissue or organs.

I. For Nondurable supplies (see Corrective Appliances).

17. Nursing Care Exclusions

A. Expenses for services of private duty nurses.

18. Prophylactic Surgery or Treatment Exclusions

Expenses for all medical or surgical services or procedures, including prescription drugs and the use of Prophylactic Surgery as defined in the Definitions section of this document, when the services, procedures, prescription of drugs, or Prophylactic Surgery is prescribed or performed for the purpose of:

A. avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or

B. treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alphafetoprotein (AFP) analysis.

19. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

A. Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.

B. Expenses for massage therapy, rolfing and related services.

C. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.

D. Expenses for Maintenance Rehabilitation as defined under Rehabilitation in the Definitions section of this document.

E. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders.

F. Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or result of a covered treatment.

20. Sexual Dysfunction Services Exclusions

A. Treatment of Sexual Dysfunction: Expenses for prescription drugs (i.e. Viagra) and/or medical or surgical treatment of sexual dysfunction (i.e., penile implants) or inadequacy, and any complications thereof.

B. Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

21. Sleep Disorders/Snoring/Obstructive Sleep Apnea

Expenses related to the medical or surgical treatment of sleep disorders or snoring, including diagnosis and medical equipment.

22. Smoking Cessation or Tobacco Withdrawal Exclusions

Expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs.

23. Transplant (Organ and Tissue) Exclusions

A. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines, and all complications thereof.

B. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.

C. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except a ventricular assist device (VAD) when used as a bridge to a heart transplant, heart valves and kidney dialysis.

D. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

24. Vision Care Exclusions

A. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).

B. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies except as provided under the Vision benefits.

C. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

25. Weight Management and Physical Fitness Exclusions

A. Medical or surgical treatment for weight-related disorders, including, but not limited to, surgical interventions, dietary programs and prescription drugs.

B. Expenses for medical or surgical treatment of obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition.

C. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.

D. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.

COORDINATION OF BENEFITS

HOW DUPLICATE COVERAGE OCCURS

This section describes the circumstances when you or your covered Dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other source (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan; or
2. Medicare; or
3. Other government program, such as Medicaid, Tricare, or a program of

the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or

4. Workers' compensation.

This section describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party. Duplicate recovery of medical and/or dental expenses may also occur if a third party caused the injury or illness by a negligent or intentional wrongful act.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides medical or dental services to the Covered Individual. A "group plan" provides its benefits or services to Employees, retirees or members of a group who are eligible for and have elected coverage.
2. Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan (or its insurer) know about all your coverages when you submit a claim**.
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

B. When two group plans cover the same person, the following order of benefit

determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a Dependent) pays first; and the plan that covers the same person as a Dependent pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a Dependent pays first; and the plan covering the person other than as a Dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

   1. the parents are married;
   2. the parents are not separated (whether or not they ever have been married); or
   3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word “Birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active Employee (that is, an Employee who is neither laid-off nor retired), or as that active Employee's Dependent, pays first; and the plan that covers the same person as a laid-off or retired Employee, or as that laid-off or retired Employee's Dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired Employee under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's Dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a Dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

   1. in the amount or scope of a plan's benefits;
   2. in the entity that pays, provides or administers the plan; or
   3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is

not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary:

When this Plan pays second, it will pay 100% of **"Allowable Expenses" less** whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If the other coordinating plan determines benefits on the basis of Usual and Customary Charges, this Plan will use the Negotiated Amount as the allowable expense.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

1. To administer COB, the Plan reserves the right, in accordance with the HIPAA Privacy Rules (see page 110), to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this

Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.
5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit, determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

COORDINATION WITH MEDICARE

A. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

B. **Coverage Under Medicare and This Plan When You Are Totally Disabled:** If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

C. **Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease:** If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

D. **How Much This Plan Pays When It Is Secondary to Medicare**

1. **When the Plan Participant Is Covered by Medicare Parts A and B:** When the plan participant is covered by Medicare Parts A and B and this plan is secondary to Medicare, this Plan pays the same benefits provided for active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the Health Care Provider.

2. **When the Plan Participant Is Covered by Medicare + Choice (Part C):** This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan Participant is covered by a Medicare + Choice (Part C of Medicare) and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Part C program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active Employees less any amounts paid by the Medicare Part C program.

   However, if the Plan Participant doesn't comply with the rules of the Medicare Part C program, including without limitation, approved referral, preauthorization, or case management requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.

3. **When the Plan Participant Is Not Covered by Medicare:** If the Plan Participant is eligible for, but is not enrolled in, Medicare, this Plan pays the same benefits provided for active Employees less the amounts that would have been paid by Medicare had the Plan Participant been covered by Medicare Parts A and B and not on the Usual and Customary Charges of the Health Care Provider.

4. **When the Plan Participant Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract

- this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

A. Medicaid: If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

B. Tricare: If a Covered Dependent is covered by both this Plan and the Tricare, the program that provides health care services to Dependents of active armed services personnel, this Plan pays first and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary and this plan is secondary.

C. Veterans Affairs Facility Services: If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services would otherwise be covered by the Plan.

D. Motor Vehicle Coverage Required by Law: If a Covered Individual is covered for medical and/or dental benefits by both this Plan and any motor vehicle coverage that is required by law, including but not limited to no-fault, uninsured motorist or underinsured motorist, the motor vehicle coverage pays first, and this Plan pays second.

E. If a Covered Individual is covered for loss of earnings by both this Plan and any motor vehicle coverage that is required by law, including no-fault, uninsured motorist or underinsured motorist, the benefits payable by this Plan on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle coverage.

F. Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION

This Plan **does not** provide benefits if the expenses are covered by workers' compensation or occupational disease law. If the Contributing Employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent or wrongful act (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions section), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent if and when there is any recovery from any third party**:

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made;
2. even if the recovery is not sufficient to make the Employee or ill or injured person whole pursuant to state law or otherwise; and
3. without any reduction for legal or other expenses incurred by any ill or injured person in connection with the recovery against the third party or that third party's insurer; and
4. except as may be expressly agreed to by the Plan at its sole discretion.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and** any ill or injured Dependent on whose behalf the Advance is made must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement on request by or on behalf of the Plan. If the Agreement is not executed at the Plan's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.**

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and the ill or injured Dependent each agree that they:

1. will reimburse the Plan from all amounts paid or payable to either of them by any third party or that third party's insurer for the entire amount of the Advance; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
3. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts and keep the Plan

Administrator informed of developments regarding any claims, actions, legal or administrative proceedings, or settlement discussions; and

4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and ill or injured Dependent jointly agree that the Plan will be subrogated to their right of recovery from a third party or that third party's insurer for the entire amount of the Advance. This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or ill or injured Dependent, but only to the extent of the amount of the Advance.
2. Under its subrogation rights, the Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advance and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or ill or injured Dependent, but in doing so, the Plan will not represent, or provide legal representation for either of them with respect to their damages that exceed any Advance; or intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. Remedies Available to the Plan

If the covered Employee or ill or injured Dependent does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of all Covered Individuals to the amount not reimbursed; or
2. obtain a judgment against the covered Employee and/or ill or injured Dependent from a court for the amount of the Advance that was not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or ill or injured Dependent.

F. Arbitration

Any dispute arising out of or relating to this "THIRD PARTY LIABILITY SECTION" or the breach thereof, shall be submitted to final and binding arbitration by an arbitrator designated by the American Arbitration Association. The arbitration will be conducted in accordance with the Federal Arbitration Act.

Claims and Appeals Procedures

This section describes the procedures for filing claims for benefits from the Local 7 Tile Industry Welfare Fund (the "Plan"). 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.

How to File a Claim

In order to file a claim for benefits offered under this Plan, you must follow the procedures outlined in this section, which may include submitting a completed claim form (where required). Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or are exclusively about eligibility 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. Benefits received from in-network providers are also not considered a "claim" under these procedures. However, if your request for any of these benefits are denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

When and Where to File Claims

Claims must be filed within twelve months following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

Your claim will be considered to have been filed as soon as it is received at the address below by the appropriate organization that is responsible for determining the initial determination of the claim.

Hospital, Medical, Dental and Optical Claims

You are generally not required to file claims for hospital (including those for in-network Multiplan facilities) or MultiPlan PPO providers in order to be reimbursed for benefits because these claims are submitted directly to Daniel H. Cook Associates, the Claims Administrator, by the Hospital and MultiPlan PPO providers.

If you use an out-of-network provider as defined on page 28, you must submit a completed claim form to:

Daniel H. Cook Associates
253 West 35th Street
New York, New York 10001
Retail Prescription Claims

You do not need claim forms when visiting a SunRx pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. In addition, if you use a non-participating pharmacy, you need to file a claim form. Contact Daniel H. Cook Associates for a claim form and file claims

at the above address.

If you need to contact SunRx, do so at the following address:

SunRx
6 Executive Campus,
Suite 400
Cherry Hill, NJ 08002
Phone:(800) 786-1791 x2020
Fax: (856) 910-7050

Death Benefit Claims

In order to file a claim for Death benefits offered under this Plan, your beneficiary should contact the Fund Office, c/o Daniel H. Cook Associates at the above address. Upon receipt of notification of the death of the participant, the Plan will provide the necessary forms to be completed by the beneficiary.

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. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Claims Procedures

The claims procedures for hospital and medical, dental, prescription, vision and death claims will vary, depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Death Benefit Claim. Please read each section carefully to determine which procedure is applicable to your request for benefits.

Pre-Service and Urgent Care Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Currently, although there are pre-authorization requirements in the Plan, there is no penalty for failure to precertify. However, if the medical review is done on a post-service basis and it is found, according to the Plan provisions and limitations, that the Hospitalization or procedure was not Medically Necessary, or was otherwise excluded under the Plan, benefits could be denied. Please see the "Pre-Review of Certain Services" in the Medical section and the "Pre-Determination Review" in the Dental Section for a description of the review process.

If a Pre-Service Claim is improperly filed, the Claims Administrator has to notify the patient as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless the patient (or representative) requested written notification. Notification of a procedural failure would only be provided if the claim was received and it included (i) the patient's name, (ii) specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it would not constitute a claim.

Under the rules for Pre-Service Claims, the patient and 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 Claims Administrator, and the patient is 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 additional information is needed, an extension notice needs to specify the information needed. In that case, the patient and/or physician 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 is suspended until the date of response to the request. The Claims Administrator has 15 days to make a decision and notify the patient of the determination. The patient has the right to appeal a denial of a pre-service claim.

Urgent Care Claim

An Urgent Care Claim is any Pre-Service Claim for medical or dental treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

(1) could seriously jeopardize the patient's life or health or ability to regain maximum function, or

(2) in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is determined by the healthcare 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 the patient's medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you are requesting precertification of an Urgent Care Claim, the time deadlines are different. The Claims Administrator will respond to you and your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim by the Plan.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claims Administrator will notify you and 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 and/or your doctor must provide the specified information within five (5) days. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the Claims Administrator receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

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 three days that is reviewed at three days to determine if additional days are appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the *termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by the Claims Administrator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon by the Claims Administrator within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Post-Service Claim

The following procedure applies to Post-Service Claims. A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

There are no claim forms to submit for MultiPlan in-network benefits, for most hospital claims and prescription drug benefits. MultiPlan Facilities and MultiPlan PPO providers will submit claims directly to the applicable payer under the terms of those contracts. Receipt of such benefits from these providers does not constitute a claim.

When you need to submit a claim, either:

- The •Provider can submit a completed Universal claims form (HCFA 1500/ UB 92 or dental form) directly to Cook or the Provider can submit a HIPAA-compliant electronic claim submission, **OR**
- You may obtain a claim form from Cook and complete the employee's portion of the claim form (including your name and social security number, the patient name, the patient's date of birth) and have your Physician complete the Attending Physician's Statement section of the claim form including Date of Service, CPT-4 code or ADA codes, ICD-9 (the diagnosis code), Billed Charge, Number of Units (for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, billing name and address and if treatment is due to accident, accident details. If you submit a universal claim form, make sure it is completely filled out.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all necessary documentation. 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.

Mail any further bills or statements for services covered by the Plan to the applicable address as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service claim within 30 days from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. 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 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 applicable organization then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Death Benefit Claims

For Death Benefits, the Plan will make a decision on the claim and notify your beneficiary within 90 days. If the Plan 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 the Plan 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.

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 state:

- The specific reason(s) for the determination,
- Reference 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, and
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

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.

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Board of Trustees:

The Local 7 Tile Industry Welfare Fund
c/o Daniel H. Cook Associates
235 West 35th Street
New York, New York 10001

You must submit your appeal in writing within 180 days after you receive notice of denial.

Your request for a review of an Urgent Claim may be made by phone by calling Daniel H. Cook, Associates at 1-877-888-AUTH (2884).

Review Process

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 in making the decision; it was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decisionmaking; 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 organization responsible for the 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 you may submit.

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.

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Board of Trustees (or Appeals Subcommittee)/Daniel H. Cook Associates.
- **Urgent Care Claims:** You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by the Board of Trustees (or Appeals Subcommittee)/Daniel H. Cook Associates.
- **Post-Service Claims:** Ordinarily, decisions on appeals involving all Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees of The Local 7 Tile Industry Welfare Fund 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 5 days after the decision has been reached.

- **Death Benefit Claims:** The decision will be made within 60 days of your beneficiary's request for review. An extension of 60 days may be granted for reasons beyond the control of the Plan. Your beneficiary will be advised in writing within the 60 days after receipt of his/her request for review if an additional period of time will be necessary to reach a final decision on the Death Benefit claim.

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 state:

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

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 3 years after the end of the year in which medical or dental services were provided.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
    - It is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
    - It provides at least one operating room and at least one post-anesthesia recovery room.
    - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
    - It has trained personnel and necessary equipment to handle emergency situations.
    - It has immediate access to a blood bank or blood supplies.
    - It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
    - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents

(anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Behavioral (Mental) Health Disorder: A Behavioral (Mental) Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things: autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this chapter. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Calendar Year: The 12-month period beginning January 1 and ending December 31. All Deductibles and Annual Maximums will be accumulated based on a calendar year. Hospital admissions will accumulate as of the admission date.

Chemical Dependency: This is another term for Substance Abuse. See the definition of Substance Abuse.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Claims Administrator: The person or company retained by the Plan to administer the claim payment responsibilities and other administration or accounting services as specified by the Plan, Daniel H. Cook Associates.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copay, Copayment: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical or Dental Expense for certain services.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation,

or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Durable Medical Equipment: Equipment that can withstand repeated use; **and** is primarily and customarily used for a medical purpose **and** is not generally useful in the absence of an injury or illness; **and** is not disposable or non-durable **and** is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Elective Hospital Admission: Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical and/or Dental Expenses: Expenses covered, in full or in part, by the Plan for medical and/or dental services or supplies, but only to the extent that they are covered in full or in part by the Plan as Medically Necessary as defined in this Section; **and** the charges for them are at the Negotiated Rate; **and** coverage for the services or supplies is not excluded; **and** the Lifetime, and/or Annual Maximum Plan benefits for those services or supplies has not been reached.

Emergency Care: Medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral (Mental) Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or in the consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, that there is either an absence of authoritative medical, dental or scientific literature on the subject, or a lack of such literature published in the United States; **and** by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or a** current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will **<u>no</u>**t be considered Experimental and/or Investigational if it is:
   - approved by the FDA as an "investigational new drug for treatment use"; **or**
   - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; **or**
   - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **<u>not</u>** approved for general use, **and** the FDA has **<u>no</u>**t determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

   In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered:**

1. Medical or dental records of the covered person;

2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopoeia Dispensing Information"; **and** "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program", etc.; **or** specialty organizations recognized by the AMA; **or** the National Institutes of Health (NIH); **or** the Center for Disease Control (CDC); **or** the Office of Technology Assessment; **or** the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare Coverage Issues Manual."

Extended Care Facility: See the definition of Skilled Nursing Facility.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Hospitals, Outpatient Ambulatory Surgical Facilities, Hospices, Skilled Nursing Facilities, Home Health Care Agency and Subacute Care Facilities, as those terms are defined in this Definitions chapter.

Health Care Provider or Provider: Includes Physician; Physician Assistant, Certified Social Worker who is licensed by the state to perform psychotherapy, Psychologist, Chiropractor; Podiatrist, Dental Hygienist; Dentist; Nurse; Nurse Practitioner, Physical, Respiratory or Speech Therapist; Speech Pathologist, Optometrist or Optician for vision plan benefits; who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Heath Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; or
2. It is licensed as a Home Health Care Agency by the regulatory authority

having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

3. If licensing is not required, it meets all of the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
    - It has a full-time administrator.
    - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
    - It maintains written clinical records of services provided to all patients.
    - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
    - Its employees are bonded.
    - It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

1. It is approved by Medicare; **or** is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
    - It provides 24 hour-a-day, 7 day-a-week service.
    - It is under the direct supervision of a duly qualified Physician.
    - It has a full-time administrator.
    - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    - The main purpose of the agency is to provide Hospice services.
    - It maintains written records of services provided to the patient.
    - It maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
2. is approved by Medicare as a Hospital; and

3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

Any portion of a Hospital used as an Ambulatory Surgical Facility, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy of a covered employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to an inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan. See also Medical Foods.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a health care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Medical Foods: Modified low protein foods and metabolic formulas as described here:

a. Modified Low Protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract **and** are processed or formulated to contain less than one gram of protein per unit of serving **and** are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients **and** such medical food is essential to the person's growth, health and metabolic homeostasis **and** are administered under the direction of a Physician for a person who has an inherited metabolic disorder.

b. Metabolic Formulas are solutions consumed or administered through the gastrointestinal tract **and** are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because

a person has limited ability to properly metabolize food or nutrients **and** such medical food is essential to the person's growth, health and metabolic homeostasis **and** are administered under the direction of a Physician for a person who has an inherited metabolic disorder. See the definition of inherited metabolic disorder.

c. Medical Foods are NOT natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders as that term is defined in this document.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a Physician, or other duly licensed Health care Provider who is authorized to provide or prescribe it, or a Dentist if a dental service or supply is involved; **and**
2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; **and**
3. is determined by the Plan Administrator or its designee to meet **<u>all</u>** of the following requirements:
   - It is consistent with the **symptoms or diagnosis and treatment of an illness or injury; and**
   - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; **and**
   - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; **and**
   - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; **and**
   - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment **and is** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as **<u>and</u>** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will

be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health care Provider to provide medical services will **not** result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

H. A medical or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health care Provider or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health care Provider, Hospital or Health Care Facility.

The deeming of a medical or dental service or supply as Medically Necessary does not ensure payment of the expenses under the Plan. Coverage may be limited or excluded by the Plan by Plan design even if a service or supply is found to be Medically Necessary.

Negotiated Rate: The amount payable to In-Network Multiplan providers for eligible medical services or supplies. For Anesthesia services that are rendered by an Out-of-Network provider when a covered individual uses an In-Network Provider and Facility for the procedure for which the Anesthesia is being administered, the Negotiated Rate will be the greater of the amount that the Claims Administrator is able to negotiate with the Provider or 80% of the actual charges. In cases of Emergency services (as defined in this document) where care is rendered by an Out-of-Network Provider because the services were obtained in an Emergency situation, the Negotiated Rate will be the greater of the amount that the Claims Administrator is able to negotiate with the Provider or 80% of the actual charges.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Devices). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CRNM) Nurse Practitioner (CRNP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse

Anesthetist (CRNA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (CRNP), who acts within the scope of his or her license and who in collaboration with a Physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Providers and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of his or her license **and** who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, **and** acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living **and** who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence.

Office Visit: A direct personal contact between a Physician or other Health Care Provider and a patient in the Health Care Provider's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. Neither a telephone discussion with a Physician or other Health care Provider, internet/virtual office visit, nor a visit to a Health Care Provider's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does not include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are not incurred.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures,

therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical disability.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD), Doctor of Osteopathy (DO), or Doctor of Podiatry (DPM) or a Dentist (DDS or DMD) for dental benefits and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan Participant: The eligible employee or eligible dependent who has enrolled for coverage under the Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled hospital admission or outpatient surgery.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting

within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Retrospective Review: Review of health care services after they have been provided to determine if those services were Medically Necessary.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; **and**
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed

Physician; **and**

3. It provides services under the supervision of Physicians; **and**
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; **and**
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; **and**
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; **and**
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapist: A person legally licensed as a professional speech therapist (or speech pathologist) who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; **and**

2. It maintains on its premises all facilities necessary for medical care and treatment; **and**
3. It provides services under the supervision of Physicians; **and**
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; **and**
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; **and**
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Surgical Assistant: A person who does not hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, and who may or may not be licensed by a state agency and who assists the primary surgeon with a surgical procedure in the operating room and who is not an employee of a health care facility and who bills, commonly as an assistant surgeon. Such individuals may be payable by this plan, including but not limited to designation as a Certified Surgical Assistant (CTA). Certified Surgical Technologist (CST), Certified First Assistant (CFA), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT) if the use of an assistant surgeon is Medically Necessary.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. For further information, see the definition of Occupational, Physical and Speech Therapy.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with an Employer as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See

also the definition of Handicap.

You, Your: When used in this document, these words refer to the employee who is covered by the Plan. They do **not** refer to any Dependent of the employee.

IMPORTANT PLAN INFORMATION

NAME OF PLAN

The Local 7 Tile Industry Welfare Fund

NAME AND ADDRESS OF PLAN SPONSOR MAINTAINING THE PLAN

Board of Trustees
The Local 7 Tile Industry Welfare Fund
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

EMPLOYER IDENTIFICATION NUMBER

38-6829766

PLAN NUMBER

501

TYPE OF PLAN

Employee Welfare benefits plan providing major medical, hospital, dental, optical, prescription drug and death benefits.

TYPE OF ADMINISTRATION AND FUNDING MEDIUM

The Local 7 Tile Industry Welfare Fund is self-funded with respect to all benefits under the Plan. All benefits except for prescription drugs are administered by Daniel H. Cook Associates. Prescription drug benefits are administered by SunRx. The preferred provider network is administered by MultiPlan, Inc.

All contributions to the Plan are made by Employers in accordance with their Collective Bargaining Agreements with Local Union 7 . The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement. The Fund Office will also provide you, upon written request, a list of Contributing Employer's and employee organizations.

The Collective Bargaining Agreements require contributions to the Plan at fixed rates per hours worked. You may request in writing, a copy of the collective bargaining agreement from the Fund Office.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and their beneficiaries and defraying reasonable administrative expenses.

Third Party Administrator

Daniel H. Cook Associates, Inc.
253 West 35th Street
New York, NY 10001
(212) 505-5050

SunRx is responsible for administrating the prescription drug benefit.
Their address is:

6 Executive Campus,
Suite 400
Cherry Hill, NJ 08002
Phone: 800-786-1791 x2020
Fax: 856-910-7050

MultiPlan administers the Preferred Provider Network (PPO).
Their address is:

115 Fifth Avenue
New York, New York 10003
Phone: 212-780-2000
Fax: 212-780-0420

PLAN ADMINISTRATOR

The Local 7 Tile Industry Welfare Fund Board of Trustees
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the self-insured benefits under the Plan, service of legal process may be made on the Plan Administrator or on any individual trustee at the addresses listed below.

PLAN TRUSTEES

Union Trustees

Ronald Ade
Marble & Terrzzo Local Union No. 7
45-34 Court Street
Long Island City, NY 11101

James Bartalone
Marble & Terrzzo Local Union No. 7
45-34 Court Street
Long Island City, NY 11101

Charles Hill
Marble & Terrzzo Local Union No. 7
45-34 Court Street
Long Island City, NY 11101

Employer Trustees

Vincent Anastasi
G. M. Crocetti Tile, Inc
39-60 Merritt Avenue
Bronx, New York 10466

Scott Erath
William Erath & Son, Inc.
4 Reith Street
Copiague, NY 11726

Louis Filippi
Atlantic Coast Tile, Inc.
187 Yorktown Blvd.
Hammonton, NJ 08037

PLAN YEAR

The Plan's fiscal records are kept on a calendar year basis beginning on January 1 and ending December 31.

NO LIABILITY FOR THE PRACTICE OF MEDICINE OR DENTISTRY

The Plan, Trustees or any of their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Physician, dentist or other provider. Neither the Plan, Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Physician, dentist or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

DISCRETIONARY AUTHORITY OF THE TRUSTEES AND THEIR DESIGNEES

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

AMENDMENT OR TERMINATION

The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules, even if extended eligibility has already been accumulated. Resolution to amend the Plan are made by the Board of Trustees and become effective on the date as specified in the document or resolution amending the Plan.

Plan benefits and eligibility rules for active, retired or disabled participants:

- are not guaranteed or otherwise vested,
- may be changed or discontinued by the Board of Trustees,
- are subject to the rules and regulations adopted by the Board of Trustees,
- are subject to the Trust Agreement which establishes and governs the Fund's operations,
- are subject to the provisions of the group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan terminates, the Trustees will apply the assets of the Fund to provide benefits or otherwise carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been dispersed.

If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any insured benefit to which you have already become entitled.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or proof that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claim Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

HIPAA PRIVACY RULES

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Welfare Fund protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Plan Administrator. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

This Plan maintains a Notice of Privacy Practices which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Privacy Officer at the Fund Office at (212) 505-5051. If you have questions about the privacy of your health information please contact the Privacy Officer. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer at the Fund Office.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. Use and disclosure of Protected Health Information (PHI): The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determining individual eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), including contribution accounting,
2. Coordination of benefits,
3. Adjudication of health benefit claims (including appeals and other payment disputes),
4. Subrogation of health benefit claims,
5. Establishing contribution rates for contributing employers, including risk adjusting amounts as necessary based, on enrollee health status and demographic characteristics,
6. Enrolling participants and dependents in the Plan (including collection of consensus card and data entry),
7. Risk adjusting amounts due based on enrollee health status and demographic characteristics,
8. Billing, collection activities and related health care data processing,
9. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes,
10. Responding to participant and beneficiary (and their authorized representatives') inquiries about claims,
11. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
12. Utilization review, including precertification, preauthorization, concurrent review and retrospective review,
13. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and
14. Reimbursement of individual overpayments to the Plan.

Health Care Operations include, but are not limited to, the following activities:

1. Quality Assessment,
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
7. Business management and general administrative activities of the entity, including, but not limited to:
   a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
   b. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
   c. Resolution of internal grievances,
   d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity, and
   e. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents.

B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

C. For purposes of this section the Board of Trustees of the Local 7 Tile Industry Welfare Fund is the "Plan Sponsor." The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
7. Make PHI available for amendment or correction and incorporate any amendments or corrections to PHI in accordance with HIPAA,
8. Make available the information required to provide an accounting of disclosures,
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and
10. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
11. Use its best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

D. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The Fund Administrator
2. Staff designated by the Fund Administrator based on their job title and function.

E. The persons described in Section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

F. If the persons described in Section D do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

H. Effective April 21, 2005, the Plan Sponsor will:

   1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan.
   2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures.
   3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
   4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Local 7 Tile Industry 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 Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator's office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report (SAR).

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependent children if there is loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to 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 Welfare Fund benefits 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 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 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 Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the 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.

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