VOLUNTARY HOSPITALS HOUSE STAFF BENEFITS PLAN (VHHSBP)

SUMMARY PLAN DESCRIPTION & PLAN DOCUMENT

Bronx Care Health System
One Brooklyn Health
Brooklyn Hospital Center
CarePoint Health - Christ Hospital
CarePoint Health - Hoboken Univ. Med. Ctr
Flushing Hospital Medical Center
Institute for Family Health-Harlem
Interfaith Medical Center
Jamaica Hospital Medical Center
Kingsbrook Jewish Medical Center
Maimonides Medical Center
New York Methodist Hospital
St. John's Episcopal Hospital
Mount Sinai Morningside/West
Wyckoff Heights Medical Center

IMPORTANT NOTICES

Your Benefits

This Summary Plan Description ("SPD") describes your benefits for the following hospitals: Bronx Care Health System, One Brooklyn Health, Brooklyn Hospital Center, CarePoint Health - Christ Hospital, CarePoint Health - Hoboken Univ. Med. Ctr, Flushing Hospital Medical Center, Institute for Family Health-Harlem, Interfaith Medical Center, Jamaica Hospital Medical Center, Kingsbrook Jewish Medical Center, Maimonides Medical Center, New York Methodist Hospital, St. John's Episcopal Hospital, Mount Sinai Morningside/West, Wyckoff Heights Medical Center.

Do not rely on statements made by individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity and whose sole decision regarding benefits is final. The Board of Trustees has not empowered anyone else to speak for them with regard to the Plan. No employer representative or supervisor is in a position to discuss your rights under the Plan with authority. If you have any questions regarding your benefits, email or write to the Board of Trustees and you will receive a written response.

The Trustees reserve the right, in their sole discretion, to (1) change or discontinue the type and amounts of benefits under this Plan, or (2) to interpret, construe, and apply the terms of the Plan or the eligibility rules, including those rules providing extended or accumulated eligibility, even if the eligibility has already been accumulated. Written amendments are periodically made to the Plan and distributed to employees and dependents. Please retain any amendments to this document for easy reference.

GENERAL PLAN INFORMATION

This document describes the Medical, Prescription Drug, Dental, Vision, Disability, Life Insurance, Hearing Aid, Employee Assistance Program, Supplemental Outpatient Mental Health and Quality Improvement (QI) benefits provided to you through the Voluntary Hospitals House Staff Benefits Plan for you and your covered dependent(s). This SPD also provides information on the Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Reconciliation Act of 1985 (COBRA), and other laws that impact your benefits. The Plan described in this document is effective January 2024, and it replaces and supersedes all other summary plan descriptions previously provided to you. You should review this SPD and also show it to those members of your family who are or will be covered by the Plan. It describes:

- the coverage provided;
- the procedures to follow when submitting claims; and
- your responsibility to provide necessary information to the Benefits Office.

***** Remember, not every expense you incur is covered by the Plan. *****

Be sure to keep this SPD, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them. For your convenience, this SPD is available by selecting your employer from the drop down menu on the Plan's website at www.cirseiu.org/benefits.

Voluntary Hospitals House Staff Benefits Plan of the Committee of Interns and Residents

10-27 46th Avenue
Suite 300-2
Long Island City, New York 11101
Phone: (212) 356-8180
Fax: (212) 356-8181
Email: benefits@cirbenefitfunds.org
Website: www.cirseiu.org/benefits

BOARD OF TRUSTEES
Anita Eliot, Union Trustee
Susan Naranjo, Union Trustee
Francesca Tinti, Employer Trustee
Bill Lynch, Employer Trustee

INTERIM FUND ADMINISTRATOR
Sheila Blanc

CERTIFIED PUBLIC ACCOUNTANT
Rogoff & Company, PC

LEGAL COUNSEL
Cohen, Weiss & Simon, LLP

PLAN CONSULTANT
Segal

January 2024

Dear Employees and Dependents,

We are pleased to present you with this Summary Plan Description (SPD). The SPD describes the benefits available to you through the Voluntary Hospitals House Staff Benefits Plan (VHHSBP) of the Committee of Interns and Residents (CIR). The SPD is intended as a summary of your benefits and also serves as the Plan Document for VHHSBP.

VHHSBP (the Plan) is a joint labor-management employee benefit trust fund, financed by contributions fixed by Collective Bargaining Agreements or other written memorandum of agreements, and is administered by an equal number of Trustees designated by the participating Employers and by the Union pursuant to an Agreement and Declaration of Trust (Trust Agreement) which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this plan of benefits described in this SPD. Under the Trust Agreement and this SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, coverage and eligibility provisions, conditions and rules at any time. In carrying out their responsibilities under the Plan, the Board of Trustees or its delegate, other Plan fiduciaries, and the insurers or administrators of the Plan, have full 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. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary or biased. Any questions of interpretation, construction, application or enforcement of the terms of the Plan and this SPD and all determinations on benefit claims and appeals are subject to the discretion of the Board of Trustees., whose determinations are final and binding. Please see the *Claims and Appeals* section for additional information governing appeals.

VHHSBP is currently funded by these participating employers: Boston Medical Center, BronxCare Health System, Brooklyn Hospital Center, CarePoint Health – Christ Hospital, CarePoint Health – Hoboken University Medical Center, Children's National Hospital, Flushing Hospital Medical Center, Institute for Family Health – Harlem, Jamaica Hospital, Maimonides Medical Center, Montefiore Medical Center (Wakefield), Mount Sinai Morningside West, New York Methodist Hospital, One Brooklyn Health (formerly Brookdale University Hospital and Medical Center, Interfaith Medical Center, Kingsbrook Jewish Hospital), St. Barnabas Hospital, St. John's Episcopal Hospital, Wyckoff Heights Medical Center, CIR, and the House Staff Benefits Plan (HSBP).

VHHSBP receives its funds pursuant to the terms of the collective bargaining agreements (CBAs) negotiated by CIR on your behalf. The CBAs require your employer to make contributions into the Plan at a fixed rate per employee.

This SPD describes the benefits to which you and your eligible dependent(s) are entitled, eligibility guidelines, rules and regulations, procedures to follow to obtain benefits, and information provided in compliance with government regulations under the Employee Retirement Income Security Act of 1974 (ERISA), COBRA, and other regulations. The Plan

operates under this SPD, the Trust Agreement, and other governing documents as further explained in the section, "Statement of Rights under ERISA." Please see the *VHHSBP General Benefits Summary* on page II.

Certain insured benefits covered in this SPD are subject to coordination of benefits, limitations and exclusions, and claims and appeals provisions contained within each of the insurers' Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificates of Insurance shall govern, and they should be read along with this SPD for a complete description of your benefits. If you would like cop(ies) of any Certificate, you may request cop(ies) from the Benefits Office.

This SPD does not create a contract of employment. The Plan makes no representation that employment with a participating employer represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment. The Board of Trustees, as Plan Sponsor, intends that the terms of the Plan, as described in this document, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

We urge you to read this SPD carefully and keep it handy. The Board of Trustees believes that your benefits will be a valuable asset to you and your family. If you have any questions regarding this material, please contact the Benefits Office at benefits@cirbenefitfunds.org or via phone (212) 356-8180.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

IMPORTANT NOTICES II
VHHSBP GENERAL BENEFITS SUMMARY 1
ELIGIBILITY AND ENROLLMENT 8
QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 16
TERMINATION AND EXTENSION OF COVERAGE 18
FAMILY AND MEDICAL LEAVE 20
CONTINUED COVERAGE IN CASES OF MILITARY LEAVE (USERRA) 21
REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE 23
MEDICAL BENEFITS 24
CHOOSING IN-NETWORK OR OUT-OF-NETWORK PROVIDERS 26
FINDING PROVIDERS AND YOUR PAYMENTS TO THEM 28
HELPING YOU MANAGE YOUR HEALTH 30
ANTHEM'S MEDICAL MANAGEMENT PROGRAM 30
ANTHEM BEHAVIORAL HEALTH UTILIZATION MANAGEMENT SERVICES 31
CASE MANAGEMENT 35
ADDITIONAL HEALTH INSURANCE INFORMATION 37
APPROVED CLINICAL TRIALS 38
GENDER AFFIRMING CARE 48
PREVENTIVE SERVICES 49
EMERGENCY CARE 53
MATERNITY CARE 57
BUILDING HEALTHY FAMILIES 58
BEHAVIORAL HEALTHCARE 59
EXCLUSIONS AND LIMITATIONS 60
DEFINITIONS 64

MEDICAL CLAIMS AND APPEALS 91
WINFERTILITY BENEFIT 97
PRESCRIPTION DRUG BENEFITS 100
EXCLUSIONS 107
PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR ELIGIBLE DEPENDENT(S) WHO ARE MEDICARE ELIGIBLE 108
DENTAL BENEFITS 114
DENTAL EXPENSE COVERAGE 114
MANAGED DENTALGUARD (MDG) 114
COVERED DENTAL SERVICES & PATIENT CHARGES 116
DENTALGUARD PREFERRED (DGP) 117
COVERED CHARGES 117
SUMMARY OF DENTAL BENEFITS FOR MANAGED DENTALGUARD AND DENTALGUARD PREFERRED PLANS 122
DENTAL CLAIMS AND APPEALS 116
DENTALGUARD PREFERRED APPEALS 121
SUPPLEMENTAL OUTPATIENT MENTAL HEALTH BENEFIT 126
VISION BENEFIT 128
EMPLOYEE ASSISTANCE PROGRAM 131
HEARING AID BENEFIT 133
QUALITY IMPROVEMENT (QI)/PATIENT SAFETY EDUCATIONAL SCHOLARSHIP BENEFIT 135
SHORT-TERM DISABILITY BENEFITS 140
INTRODUCTION 140
DEFINITION OF DISABLED 140
DURATION OF BENEFITS 140
LIMITATION ON DISABILITY 140
REDUCTION OF BENEFITS 140
EXCLUSIONS 141

FILING A DISABILITY CLAIM 141

NOTICE OF DECISION 142

APPEALS 142

QUALIFIED NEW YORK EMPLOYERS 142

LONG-TERM DISABILITY 144

LONG TERM DISABILITY CLAIMS AND APPEALS 148

EXTENSION OF MEDICAL COVERAGE DURING TOTAL DISABILITY 151

TERM LIFE INSURANCE 152

TERM LIFE INSURANCE DURING TOTAL DISABILITY 153

LIFE INSURANCE CLAIMS AND APPEALS 155

TERM LIFE INSURANCE FOR YOUR DEPENDENT SPOUSE OR REGISTERED DOMESTIC PARTNER 157

CONVERSION TO AN INDIVIDUAL POLICY FOR A SPOUSE 157

ANCILLARY DEATH BENEFIT 159

ACCIDENTAL DISMEMBERMENT BENEFIT 160

CLAIMS AND APPEALS 162

CLAIMS REVIEW AND APPEAL PROCEDURE 163

ADDITIONAL INFORMATION REGARDING CLAIMS AND APPEALS 168

COORDINATION OF BENEFITS 170

OTHER IMPORTANT INFORMATION AND REQUIRED NOTICES 176

PLAN AMENDMENT AND TERMINATION 180

THIRD PARTY LIABILITY 181

COBRA CONTINUATION COVERAGE 183

NOTICE OF ELECTRONIC DISCLOSURE 194

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 196

ERISA STATEMENT OF RIGHTS UNDER THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 201

VHHSBP GENERAL BENEFITS SUMMARY

BENEFIT CYCLE: JULY 1 – JUNE 30

Benefit	Insurer	Contact	Other Important Documents Incorporated into this SPD
Short-Term Disability	VHHSBP or Insured by Standard Security Life Insurance	Benefits Office 10-27 46th Avenue, Suite 300-2 Long Island City, New York 11101 (212) 356-8180 benefits@cirbenefitfunds.org	N/A
Quality Improvement	VHHSBP		N/A
Supplemental Outpatient Mental Health	VHHSBP		N/A
Medical	VHHSBP (Administered by Anthem Blue Cross Blue Shield)[1]	Anthem Blue Cross Blue Shield Group# - 720070 www.Anthem.com (888) 548-3432 (POS) (844) 243-5566 (PPO)	N/A
Prescription Drug	VHHSBP (Administered by Express Scripts)	Express Scripts Inc. (ESI) Group #K4DA (866) 439-3658 www.express-scripts.com	
Dental Coverage • Managed DentalGuard (MDG) • Dental Guard Preferred (DGP)	Guardian	Guardian Dental Group #G417733 www.guardianlife.com (888) 600-1600	Guardian Dental Certificate of Coverage Class #1 (Managed DentalGuard) Guardian Dental Certificate of Coverage Class #3 (DentalGuard Preferred)
Hearing Aid	VHHSBP	EPIC Hearing (866) 956-5400 www.epichearing.com	N/A
Employee Assistance Program (EAP)	Guardian	(800) 386-7055 www.ibhworklife.com Username: Matters Password: wlm70101	
Life Insurance[2]	Guardian	Guardian	

[1] Empire Blue Cross Blue Shield changed its name to Anthem Blue Cross and Blue Shield effective January 1, 2024.

[2] Not available at Boston Medical Center or St. Barnabas Hospital.

Long-Term Disability	Guardian	Group #348566 (800) 525-4542	Guardian Basic Life and Long-Term Disability Certificate of Coverage Class #1
Vision	VHHSBP (Administered by Davis Vision)	Davis Vision Group# 2189 www.davisvision.com (800) 999-5431	

MEDICAL	For Employee/Spouse or Registered Domestic Partner/Dependent	
	IN-NETWORK	OUT-OF-NETWORK
1) Online Doctor Visits 2) Doctor Office Visits 3) Specialist Office Visits	$20 copay per visit	You pay 30% of the Maximum Allowed Amount after the Deductible is met
Emergency Copayment (waived if admitted within 24 hours).	$100	$100
Deductible per Benefit Cycle (July 1 - June 30) Coinsurance	N/A	Deductible • $1,000 Individual / $2,000 Family Coinsurance • 30% Coinsurance of Maximum Allowed Amount after Deductible is met
Out-of-Pocket Maximum (OOP) per Benefit Cycle (July 1 - June 30) (Deductible, Coinsurance, and Copayments)	Medical: $1,500/Individual and $3,000/Family Prescription (Express Scripts): $2,500/Individual and $5,000/Family Medical and Prescription Combined: $4,000/Individual and $8,000/Family	$2,000 Individual/$4,000 for a Family of two/$5,000 Family of three or more; Maximum Allowed Amount (Deductible and Prescription included)

Lifetime maximum	Unlimited	Unlimited
DENTAL	For Employee/Spouse or Registered Domestic Partner/Dependent	
	IN-NETWORK	OUT-OF-NETWORK
Managed DentalGuard (MDG) 1) Preventative & Basic Services 2) Major Services 3) Orthodontic Services 4) Annual Maximum	Please see Dental Benefits section	Not Covered
DentalGuard Preferred (DGP) 1) Preventative 2) Basic Services 3) Major Services 4) In-Network Annual Maximum 5) Orthodontic services	Please see Dental Benefits section	Please see Dental Benefits section

PHARMACY (RX)	For Employee/Spouse or Registered Domestic Partner/Dependent	
	IN-NETWORK *Copayments Apply to Out-of-Pocket Maximum, see above	OUT-OF-NETWORK
Retail (up to 30-day supply) 1) Generic 2) Formulary (Preferred Brand) 3) Non-Formulary (Non-Preferred Brand)	**Copayment** 1) $5 2) $15 3) $30	See Prescription Benefits Section
Home Delivery (31 to 90-day supply) *less than 31-day supply, retail Copayments apply*	**Copayment**	

1) Generic 2) Formulary (Preferred Brand) 3) Non-Formulary (Non-Preferred Brand)	1) $10 2) $30 3) $60	Not covered
VISION	For Employee/Spouse or Registered Domestic Partner/Dependent	
	IN-NETWORK	OUT-OF-NETWORK
Eye exam	Free once per Benefit Cycle (July 1 to June 30)	Covered up to $40 per Benefit Cycle
Contact Lens Evaluation & Fitting Fee	15% discount once per Benefit Cycle (July 1 to June 30)	
Spectacle Lenses	Free once per Benefit Cycle (July 1 to June 30)	Covered up to $60 per Benefit Cycle
Frames	Every other Benefit Cycle (July 1 to June 30): • $0 copay for Fashion Frame selection OR • $15 copay for "Designer" Frame selection OR • $40 copay for "Premier" frame selection OR • $50 toward any frame plus 20% off balance* (if any)	
Contact Lenses (in lieu of eyeglasses)	$100 allowance per Benefit Cycle (July 1 to June 30) plus	

* Some limitations apply to additional discounts; discounts not applicable at all in-network providers.

	15% off any balance* OR Visually required contacts, up to $135 per Benefit Cycle with prior approval	
Mail Order	Discount for contact lenses at www.800contacts.com	
HEARING AID	For Employee/Spouse or Registered Domestic Partner/Dependent	
	IN-NETWORK ONLY When calling EPIC Hearing Healthcare, you must mention that you are a CIR VHHSBP member	
Maximum	$1,500 per ear per lifetime	
SHORT-TERM DISABILITY	For Employee Only	
Weekly Income Benefit	60% of basic weekly salary up to $692	
Maximum Weekly Benefit Payment Period	Up to 26 weeks after 7th day minus integrated income (New York State income, etc.)	
Paid Family Leave	Based on State regulations	
LONG-TERM DISABILITY	For Employee Only	
Maximum Monthly Benefit and Payment Period	60% of monthly earnings to a max of $3,500 up to age 65. Up to five years of coverage for mental health and/or substance use, non-hospitalized and emotional disorders.	
LIFE INSURANCE	For Employee/Spouse or Registered Domestic Partner*	
	Employee	Spouse or Registered Domestic Partner
Term Life	$125,000	$20,000
ACCIDENTAL DISMEMBERMENT	For Employee Only	

	$50,000 $20,000 (partial)
EMPLOYEE ASSISTANCE PROGRAM (EAP)	For/Spouse or Registered Domestic Partner/Dependent
	BENEFIT
24 HOURS / 7 DAYS A WEEK CONFIDENTIAL FREE ACCESS	• Behavioral Health Counselors • Behavioral Health Consumer Information • Chat with a Counselor • Email a Counselor • WorkLife Resources
SUPPLEMENTAL OUTPATIENT MENTAL HEALTH BENEFIT	For Employee/Spouse or Registered Domestic Partner/Dependent
The Plan will reimburse 100% of the out-of-pocket expenses (Copayment, Coinsurance, and Deductible) not to exceed $200 per office visit for outpatient mental health services up to $5,000 per Benefit Cycle per participant. The services must be covered by the medical coverage provided by this Plan through Anthem or, in the case of participants employed by Children's National Hospital (CNH), by CNH.	
QUALITY IMPROVEMENT (QI) BENEFIT	For Employee Only
	BENEFITS
Types of Quality Improvement (QI) Conferences	**1. QI/Patient Safety Conference** • The Plan will fund QI/Patient Safety Learning Events to disseminate QI/Patient Safety resources. • All covered employees are invited to attend events and to access resources created at no cost.

	2. QI/Patient Safety Education and Training Scholarships • Scholarship reimbursements will be awarded for eligible covered employees • Up to $3,000 reimbursement for a resident to attend one Patient Safety Education and Training Program • Plan pre-approval is required; the application is on the CIR website at www.cirseiu.org/benefits and select your Employer from the dropdown menu. The post-attendance reimbursement claim form is also found at the above link. For a list of recommended U.S.-sponsored conferences or events, please see the QI section below.

ELIGIBILITY AND ENROLLMENT

<u>Effective Date of Eligibility</u>

To become eligible for benefits under the Plan, you must work a minimum of 20 hours per week and contributions must be received on your behalf. The following rules apply to determine the effective date of your eligibility:

- If you start working and go on your employer's payroll between the 1st of the month and the 15th of the month and contributions are required to be made to this Plan on your behalf, you and your eligible dependent(s) will become eligible for benefits on the day you go on payroll.
- If you go on your employer's payroll between the 16th of the month and the last day of the month and contributions are required to be made to this Plan on your behalf, you and your eligible dependent(s) will become eligible for benefits on the first day of the following month.
- Employees who rotate off the payroll of a VHHSBP participating employer and rotate back will be able to recommence benefits immediately.

You must complete an Enrollment Form to enroll for benefits.

Rotation Away From Participating Employer

If, during a rotation, you switch from your current hospital's payroll to the payroll of a hospital that is not a participating employer of VHHSBP, your VHHSBP benefits cease for such period, and you cannot submit a claim for any costs incurred during such period.

Your VHHSBP benefits coverage resumes on the day you return to a VHHSBP-participating employer payroll.

<u>Dependent(s) Eligibility</u>

Coverage of your eligible dependent(s) begins on the same day your coverage begins as long as you enroll them when you complete your Enrollment Form and provide sufficient proof of eligibility.

Not all of your dependents receive the same benefits:

Your spouse and dependent child(ren) are eligible for the same benefits as you, at no cost to you, with the exception of Accidental Dismemberment, EAP, QI, and Short-Term and Long-Term Disability Benefits, which are only available to you, the employee.

Term life insurance in the amount of $20,000 is only available to your enrolled spouse or registered domestic partner.

BENEFIT ELIGIBILITY CHART **(an X below indicates eligibility for the benefit)**

Benefit	Employee	Dependent Children	Spouse/Domestic Partner
Accidental Dismemberment	X		
Dental Benefit	X	X	X
Employee Assistance Program	X	X	X
Hearing Aid Benefit	X	X	X
Life Insurance	X		X
Major Medical/Hospitalization Benefits	X	X	X
Quality Improvement Benefit	X		
Prescription Drug Benefit	X	X	X
Short-Term and Long-Term Disability	X		
Supplemental Outpatient Mental Health Benefit	X	X	X
Vision Benefit	X	X	X

We will not provide benefits to your eligible dependent(s) without a completed Enrollment Form and the required proof of dependent status (discussed below).

Your eligible dependent(s) include:

- Your spouse to whom you are legally married;
- Your domestic partner;
- A dependent child, up to the end of the calendar year of their 26th birthday, including:
    - your biological child;
    - your legally adopted child or a child placed for adoption ("placed for adoption") assumes retention by the employee of a legal obligation for total or partial support of such child in anticipation of adoption);
    - a stepchild or foster-child;
    - your domestic partner's child (see below for specific details);
    - an unmarried individual whom the employee has legal guardianship under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the Internal Revenue Code Section 152(c) or 152(d) or who will be claimed as a dependent on the employee's tax return each plan year for which coverage is provided; and
    - a child named as an "alternate recipient" under a Qualified Medical Child Support Order.

- Unmarried Disabled Children regardless of age:
    - Coverage for dependent children will not terminate for unmarried disabled children who, regardless of age, are incapable of self-sustaining employment by reason of mental disability, developmental disability, or physical disability, and who became disabled prior to reaching the age limit of the VHHSBP.
    - Such coverage shall not terminate while the Employee's coverage remains in effect, and the dependent remains disabled and is chiefly dependent on the Employee for support and maintenance.
    - The Employee must submit proof of the dependent's incapacity within 31 days of dependent's attainment of age limit.

Coverage is available whether the child is married or unmarried, regardless of student status, employment status, financial dependency on the Employee, or any other factor other than the relationship between the child and the Employee.

A spouse or child of a Dependent Child is not eligible for coverage under the Plan.

Enrollment Information

You must complete an Enrollment Form in order to be eligible for benefits for yourself and your eligible dependent(s).

The Enrollment Form must be received by the Benefits Office within 31 days of the date you are hired. If the completed form is received within the necessary time frame, benefits are effective as described in the "Effective Date of Eligibility" Section. If your enrollment form is received after 31 days from the date of your hire, you will be automatically enrolled during the next Open Enrollment periods offered by the Plan, with an effective date of either January 1 or July 1. However, you may seek enrollment sooner if you qualify for Special Enrollment (as described later in this section). Follow the instructions on the Enrollment Form to complete your enrollment.

Any information that you provide about yourself (and/or eligible dependent(s)) will be kept strictly confidential. Attach clear copies of any legal documents required for enrollment (do not send originals).

Please note: the Benefits Office prefers that all forms and requests be submitted through the CIR website and member portal. If the portal cannot be used, forms and requests will be accepted by email sent to benefits@cirbenefitfunds.org.

If you do not complete and return an Enrollment Form, you (and your dependents, if applicable) will not be eligible for benefits and claims will be denied under the Plan.

Enrolling Eligible Dependent(s)

If you have eligible dependents you wish to enroll, you must provide necessary proof of dependent status as listed below along with the Enrollment Form. If the Benefits Office does not receive a

completed Enrollment Form and the documentation listed below, the Benefits Office will not enroll and will not provide benefits to your dependent(s) and claims will be denied under the Plan.

- Spouse: To enroll your spouse, you must provide a copy of your official, state-issued marriage certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized.
- Biological Child: To enroll your biological child(ren), you must provide a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized.
- Stepchild: To enroll stepchild(ren), you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the official, state-issued marriage certificate between you and your spouse as the child(ren)'s parent (or the Plan's form affidavit, which has been notarized).
- Adopted Child or Placement for Adoption: To enroll adopted child(ren) or child(ren) placed for adoption, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the certified court order signed by a judge.
- Child covered pursuant to a Qualified Medical Child Support Order (QMCSO): To enroll child(ren) covered pursuant to a QMCSO, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the certified QMCSO document signed by a judge or a National Medical Support Notice.
- Legal Guardianship: To enroll child(ren) for whom you are a legal guardian, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, which has been notarized, and 2) a copy of the court-appointed legal guardianship documents.
- Unmarried Disabled Dependent Child: As discussed above, coverage will not terminate for unmarried disabled children who, regardless of age, are incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical disability, and who became disabled prior to reaching the age limit, so long as the Employee's coverage remains in effect and the dependent remains disabled and chiefly dependent on the Employee for support and maintenance. If you have not provided the information below upon enrolling your disabled dependent child, you **must** submit proof of the dependent's incapacity within 31 days of the disabled dependent child's attainment of age limit to maintain enrollment of the disabled dependent child. You must provide:

    1. a current written statement from the child's physician indicating the physician's assessment that the child is currently mentally or physically disabled;

2. a notarized statement that the child is incapable of self-sustaining employment as a result of that disability; and

3. a notarized statement and proof that the child is dependent chiefly on you and/or your spouse for support and maintenance.

Enrolling Domestic Partners

To enroll your domestic partner and/or the child(ren) of your domestic partner, you must complete an Enrollment Form **and** a Domestic Partnership Application.

1. The Application must be signed by both partners and notarized.

2. If you have a registered domestic partnership, you must provide proof that you are registered as domestic partners. If your domestic partnership certificate cannot be located, you may also complete the Plan's form affidavit, which must be notarized. The Plan's form affidavit can be found at cirseiu.org, click on "Benefits" at the top and select your Employer from the dropdown menu.

3. If you are not providing proof of a registered domestic partnership, you must prove domestic partnership status by providing documentation to show two (2) of the following:

    - Common ownership of real property or a common leasehold interest in such property
    - Common ownership of a motor vehicle
    - Joint bank accounts or credit accounts
    - Evidence of common household expenses such as a utility or telephone
    - Evidence of joint obligation on a loan
    - Designation as a beneficiary for life insurance or retirement benefits or under the partner's will
    - Assignment of a durable power of attorney or health care power of attorney

Without this documentation your domestic partner will NOT be covered.

Domestic Partners will generally not qualify as tax dependents of the employee and as such, you will be taxed on the value of the benefit provided to the Domestic Partner. In some situations, you may also be responsible for paying taxes on the value of benefits provided to the child(ren) of your domestic partner. You will be notified of the amount by your participating employer. Please consult with an appropriate tax accountant if you choose to enroll a domestic partner or the child(ren) of your domestic partner.

Change in Family Status
You must notify the Benefits Office within 31 days when you have a change in family status and/or want to change your life insurance beneficiary by completing an Update Form and sending it to benefits@cirbenefitfunds.org. A change in family status occurs in the event of:

- The death of an enrolled dependent child, spouse, or domestic partner.
- You are divorced, your marriage is annulled, or you terminate your domestic partnership relationship.
- Your dependent child reaches the Plan's age limit.

It is your responsibility to ensure that the Benefits Office has up to date information for you and your enrolled dependents. Please notify the Benefits Office within 31 days by completing an Update Form and sending it to benefits@cirbenefitfunds.org when any of the following occurs:

- You or your eligible dependent has a name change.
- You or your eligible dependent has an address change.
- You move out of your health or dental plan's coverage area.
- You receive or change your Social Security Number.
- Your dependent child(ren) becomes physically or mentally disabled.
- You or your eligible dependent(s) becomes enrolled in, or loses, coverage under Medicare.
- You or your eligible dependent(s) becomes enrolled in, or loses, coverage under another medical or dental plan.
- Social Security disability benefits are awarded or terminated for you or your eligible dependent(s).

All changes in status require copies of the appropriate documents to be attached to the **Update Form** before submitting it to the Benefits Office. Without the appropriate document(s), the benefits coverage may be denied or interrupted.

Failure to give the Plan timely notice of changes to your spouse, domestic partner, and/or dependent child(ren)'s eligibility status will cause your spouse, domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child to end when it otherwise might continue because of a physical or mental disability. If you fail to provide notice to the Plan and your ineligible spouse, domestic partner, and/or dependent child(ren) remain covered, you will be responsible for reimbursing the Plan for any claims or any premiums that are paid on behalf of your dependent child, spouse, or domestic partner who are no longer eligible for coverage under the Plan. The Board of Trustees may commence legal action against an employee or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the employee or dependent to recover amounts owed.

Open Enrollment

This Plan has two Open Enrollment periods each year:

1. June 1st through July 31st, with an effective date of July 1st; and
2. December 1st through January 31st, with an effective date of January 1st.

If you do not enroll yourself and/or your dependent(s) when you are first eligible for coverage within thirty-one (31) days of your hire date, you may enroll yourself and your eligible dependent(s) during either of the Open Enrollment periods. During Open Enrollment, you will also be able to switch between dental options. Please see the *Special Enrollment* section for additional ways you may enroll yourself or your eligible dependent(s) outside of your initial eligibility or open enrollment.

Opt-Out

If you initially enrolled yourself and/or your dependent(s) and later wish to dis-enroll yourself and/or any or all of your dependent(s) you and your dependent(s) will be required to complete an electronic Disenrollment Form and provide proof of other coverage.

If, at a later date, you want the coverage you declined for yourself and/or your dependent(s), you may enroll only under the Special Enrollment provisions described below or during the two Open Enrollment periods.

Note that no additional compensation is paid to you if you or your eligible dependent(s) waive/decline benefit coverage.

Special Enrollment

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future enroll yourself and/or eligible dependents in the Plan, if you request enrollment within thirty-one (31) days from the date your or their previous coverage ends (or the participating 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 your dependents, provided that you request enrollment within thirty-one (31) days from the date of marriage, birth, adoption, or placement for adoption.

If you did not enroll yourself or your dependent(s) in the Plan when first eligible, you may enroll yourself if you and your dependent(s) have coverage through Medicaid or a State Child(ren)'s Health Insurance Program (SCHIP) and lose eligibility for that coverage. In addition, you may also enroll yourself and/or your dependent(s) in the Plan if you and/or they become eligible for a premium assistance program through Medicaid or SCHIP. However, you must request enrollment within 60 days after the loss of coverage through Medicaid or SCHIP or eligibility for a premium assistance program through Medicaid or SCHIP.

To request special enrollment, submit your information and documents within the applicable thirty-one (31) day or sixty (60) day deadline set forth above to the Benefits Office by visiting the CIR website at https://www.cirseiu.org/benefits and submitting an Update Form.

Start of Coverage Following Special Enrollment

Provided you enroll within the necessary timeframes for Special Enrollment, coverage will be effective:

- If you add a new dependent due to the birth of that dependent, the dependent will be covered from the date of birth (provided you enroll a baby within thirty-one (31) days).
- Your newly adopted dependent child or child "placed for adoption" with you will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support for the child whom you plan to adopt. A child who is placed for adoption with you within thirty-one (31) days after the child is born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. 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 within thirty-one (31) days of your marriage. Until your spouse is enrolled in the Plan, no claims will be paid for him or her.
- Following loss of other group coverage: your dependent(s) will be covered retroactive to date of loss of other coverage, provided you enroll your dependent(s) within thirty-one (31) days of the loss of that other coverage.
- Following loss of coverage under or eligibility for Medicaid/SCHIP, provided you enroll within sixty (60) days of the loss of Medicaid/SCHIP coverage, your coverage change will become effective the date of your request.

Please note: the Benefits Office prefers that all forms and requests be submitted through the CIR website and member portal. If the portal cannot be used, forms and requests will be accepted by email sent to **benefits@cirbenefitfunds.org**.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

VHHSBP will provides benefits in accordance with a Qualified Medical Child Support Order (QMCSO). In this document, the term QMCSO is used and includes compliance with a National Medical Support Order (NMSO). According to federal law, a QMCSO is a judgment, decree, or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. A QMCSO usually results from a divorce or legal separation and typically:

- designates one parent to pay for a child's health plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies; and
- identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, or if it requires someone who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your dependent children, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on you, the other parent, the child, and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if you are covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). All QMSCOs should be directed to the Benefits Office.

For additional information regarding procedures for the administration of QMCSOs, contact the Benefits Office.

Enrollment Related to a Valid QMCSO

If the Plan determines a QMCSO is valid, it will accept enrollment of the alternate recipient as of the earliest date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.

- If the employee already participates in the Plan, the QMCSO may require the Plan to provide coverage for the employee's dependent child(ren) and to accept contributions for that coverage from a parent who does not participate in the Plan. The Plan will accept a QMCSO Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received.

- If the employee does not participate in the Plan when the QMCSO is received and the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received.

- Coverage will be subject to all terms and provisions of the Plan, including any limits on selection of Provider and requirements for authorization of services, as permitted by applicable law.

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other dependent children. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. For COBRA eligibility and enrollment requirements, see the COBRA section of this document.

TERMINATION AND EXTENSION OF COVERAGE

When Coverage Ends

Your coverage ends on the last day of the month in which:

- your employment ends;
- you are no longer eligible to participate in the Plan, including, but not limited to, if you switch from your current hospital's payroll to the payroll of a hospital that is not a participating employer of VHHSBP; or
- you enter active military service lasting more than thirty-one (31) days.

Coverage of your covered dependent(s) ends on the last day of the month in which:

- your own coverage ends; or
- your covered spouse, domestic partner, or dependent child(ren) no longer meet the definition of spouse, domestic partner, or dependent child(ren).

Failure to give the Plan timely notice of changes to your spouse, domestic partner, and/or dependent child(ren)'s eligibility status will cause your spouse, domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child to end when it otherwise might continue because of a physical or mental disability. If you fail to provide notice to the Plan and your ineligible spouse, domestic partner, and/or dependent child(ren) remain covered, you will be responsible for reimbursing the Plan for any claims or any premiums that are paid on behalf of your dependent child, spouse, or domestic partner who are no longer eligible for coverage under the Plan.

Coverage for you (the employee) and/or your Dependents may be terminated retroactively due to non-payment of premiums (including COBRA premiums). Failure to notify the Plan of a loss of dependent status for any dependents (including divorce or legal separation or a child aging out of the Plan or a child no longer meeting the definition of disabled child) coupled with a failure to pay COBRA premiums will cause coverage to be terminated retroactively to the date of the event.

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

If you have questions about the definitions used in this section, please refer to the section on Eligibility earlier in this SPD, or email or call the Benefits Office at benefits@cirbenefitfunds.org or (212) 356-8180.

Please note: the Benefits Office prefers that all forms and requests be submitted through the CIR website and member portal. If the portal cannot be used, forms and requests will be accepted by email sent to benefits@cirbenefitfunds.org.

Rescission of Coverage

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the Provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim.

Coverage for you (the employee) and/or your Dependents may be terminated retroactively (rescinded) in cases of fraud or intentional misrepresentation. In such cases, you will be provided with thirty (30) day advance notice that coverage will be rescinded.

Note that a retroactive termination of coverage due to non-payment of premiums (including COBRA premiums) is not considered a rescission. Similarly, a retroactive termination due to your failure to notify the Plan of a loss of eligibility for your spouse due to divorce will not constitute a rescission of coverage if COBRA premiums have also not been paid. In these situations, coverage will be terminated retroactively to the date of the event (without advance notice).

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

Extension and Continuation of Coverage

Your Plan does not provide benefits for any expenses incurred after coverage ends. However, there are times when your coverage can be continued. Refer to the sections on COBRA Continuation Coverage, Family and Medical Leave, Extension and Continuation of Coverage Under Disability, and USERRA for more information.

Contact the Benefits Office for more information.

FAMILY AND MEDICAL LEAVE

If you have worked at least 1,250 hours in the last twelve (12) months, completed twelve (12) months of employment and you work for an employer covered by the Family and Medical Leave Act (FMLA), you may be entitled by law to up to twelve (12) weeks each year of unpaid family and medical leave 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. Your participating employer is responsible for determining and granting the leave and will notify the Benefits Office when you take a leave subject to FMLA.

The Plan will continue benefits for you and your dependents, if applicable, during your leave on the same basis as prior to the beginning of the leave. You will be responsible for making any required employee contributions. Your participating employer must remit the required contributions to the Plan during your FMLA leave. While you are officially on such a FMLA leave, you can keep benefit coverages for yourself and your dependents in effect during that FMLA leave period by continuing to pay any required contributions.

You may also be eligible to take paid family leave under state Paid Family and Medical Leave (PFML) laws, such as the New York Paid Family Leave Law or other applicable state statutory leave laws.

If you are eligible for FMLA, New York Paid Family Leave, or other statutory leave, your participating employer is responsible for granting the leave and will notify the Benefits Office when you take a leave. Provided your participating employer notifies the Benefits Office and makes the required contributions to the Plan on your behalf, the Plan will continue benefits for you and your dependents during your leave on the same basis as prior to the beginning of the leave. You will be responsible for making any required employee contributions.

Any changes in the Plans terms, rules or practices that go into effect while you are away on leave will apply to you and your dependents in the same way they apply to all other employees and their dependents. Please note: family and medical leave is your participating employer's responsibility so you will only be eligible for benefits if the Plan continues to receive contributions from your participating employer.

To find out more about family and medical leave and the terms on which you may be entitled to it, contact your participating employer's human resources or personnel office. If you have any questions about how a leave of absence affects your benefits, please contact the Benefits Office.

CONTINUED COVERAGE IN CASES OF MILITARY LEAVE (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for a temporary continuation of health coverage when it would otherwise end because you have been called to active military duty. USERRA protects employees who leave for, and return from, any type of uniformed service in the United States armed forces.

Paying for USERRA Coverage: If you are on active military duty for thirty (30) days or less, you (and any eligible dependents covered under the Plan on the day your leave starts) will continue to receive health coverage in accordance with USERRA at no cost to you.

If you are on active military duty for thirty-one (31) or more days, USERRA permits you to continue your coverage under the Plan for you and your dependents, at your own expense, for the lesser of (i) twenty-four (24) months, or (ii) the period of qualified military service (i.e., generally, the period beginning on the date that your qualified military absence begins and ending on the date on which you fail to apply for, or return to, a position with your participating employer).

In addition to USERRA or COBRA coverage, your eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

Duty to Notify: The Plan will offer you USERRA Continuation Coverage only after the Benefits Office has been notified by you in writing that you have been called to active duty in the uniformed services and you provide a copy of the orders. You must notify the Benefits Office as far in advance as is reasonable under the circumstances, that you are leaving for military service and will lose coverage, unless circumstances or military necessity make notification impossible or unreasonable.

Electing Continuation Coverage: Once the Plan receives notice that you have been called to active duty, the Plan will offer you (and any eligible dependents covered under the Plan on the day the leave started) the right to elect to continue coverage. The Plan's rules regarding the procedures for electing and paying for COBRA coverage apply to USERRA continuation coverage. Please contact the Benefits Office should you have any questions regarding USERRA continuation coverage.

NOTE: Unlike COBRA continuation coverage, if you do not elect USERRA continuation coverage for your dependents, they cannot separately elect to continue coverage. Also note that you (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA continuation coverage when you lose coverage due to military service. However, the continuation coverage provided pursuant to USERRA is an alternative to COBRA and, therefore, the two continuation periods will not run consecutively. Please review the COBRA section of this SPD for additional information.

After Discharge from the Armed Forces: Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage under the Plan reinstated when you return to covered employment with a participating employer following your discharge (not less than honorably) from the uniformed services, provided that you return to employment within:

- Ninety (90) days from the date of discharge from the military if the period of service was more than one-hundred eighty (180) days; or
- Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
- 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 (8) hours), if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two (2) years.

You must notify the Benefits Office in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved leave of absence under family, medical, military, or other statutory leave law, your coverage will be reinstated on the first day of the month following your return to active employment, if you return within fourteen (14) days after your leave of absence ends, subject to all accumulated Annual Maximum Benefits that were incurred prior to the leave of absence.

If your coverage ends while you are on an approved leave of absence other than leave taken under family, medical, or military leave, your coverage will be reinstated on the first day of the month following your return to active employment, if you return immediately after your leave of absence ends, subject to any Annual Maximum Plan Benefits that were incurred prior to the leave of absence.

If you qualify for an approved leave of absence from your participating employer under family, medical, military, or other statutory leave law, and then inform your participating employer that you are not returning to work, the Plan will consider your employment as having been terminated, and your coverage will cease on the first day of the first month following the month in which your participating employer last makes a contribution on your behalf. Upon this termination of coverage, you will be eligible to elect COBRA continuation coverage.

Any period of any approved leave of absence, including a leave of absence under family, medical, military, or other statutory leave law, will not be counted as a Break in Coverage. Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to your participating employer.

If you have any questions about taking a leave, please speak directly with your participating employer. If you have any questions about how a leave of absence affects your benefits, please contact the Benefits Office.

MEDICAL BENEFITS

Your medical benefits are provided by Anthem Blue Cross Blue Shield. Anthem Blue Cross Blue Shiel changed its name to Anthem Blue Cross and Blue Shield effective January 1, 2024.

Anthem Blue Cross Blue Shield offers a network of healthcare Providers that have contracted with Anthem to offer you special rates. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

With the Anthem network, you have access to flexible, quality healthcare coverage.

This section summarizes:

- How you get healthcare services
- What your health plan covers
- How you can make the most of your plan.

WHAT'S THE ADVANTAGE OF ANTHEM'S NETWORK?

With Anthem, when you need healthcare services, you have a choice. Depending on the care you need, you are free to get care from Providers participating in Anthem's Network (In-Network Providers) or you can choose to use a Provider outside of the network (Out-of-Network Providers). You may receive medically necessary services both In and Out-of-Network. Choices such as this allow you to make smart decisions about your healthcare.

You will be automatically enrolled in Anthem's DirectShare^{SM} POS Network if you reside in New York State; you will be automatically enrolled in Anthem's Preferred Provider Organization (PPO) Network if you reside outside of New York State.

Other advantages of your plan include:

- The freedom to self-refer to the network specialist of your choice;
- Lower costs when you use In-Network Providers;
- Access to a large networks of doctors and hospitals;
- Providers that are rigorously reviewed to meet Anthem's high standards of quality;
- A comprehensive website, www.Anthem.com, for fast, personalized healthcare information and management in a confidential environment.

PREFERRED PROVIDER ORGANIZATION (PPO)

- If you reside outside of New York State, you will be enrolled in the Preferred Provider Organization (PPO) Network.
- Proof of residence is required.
- Levels of coverage and costs are similar to the POS Network.

For more information about the POS or PPO Networks, contact the Benefits Office at (212) 356-8180 or email benefits@cirbenefitfunds.org.

Anthem Contact Information

TO CONTACT ON THE INTERNET

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

Concerned about using your personal computer for important healthcare questions or transactions? Anthem has addressed that too! Just "click to talk" to a representative or send Anthem an e-mail.

TO CONTACT BY TELEPHONE

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership.	**(844) 243-5566** TDD for hearing impaired: **(800) 241-6894** 8:30 a.m. to 5:00 p.m. (EST) Monday – Friday
LiveHealth Online	LiveHealth Online healthcare professionals are available 24/7 to give advice, help with treatment options, and write prescriptions, if needed. Services are available on an In-Network Only basis.	www.livehealthonline.com
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**(844) 243-5566** Por favor ermanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor. 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
ANTHEM MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures.	**(800) 982-8089** 8:30 a.m. to 5:00 p.m. (EST) Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes on health-related topics.	**(877) TALK-2RN (825-5276)** 24 hours a day, 7 days a week
ANTHEM BEHAVIORAL HEALTH UTILIZATION MANAGEMENT SERVICES	To locate a participating behavioral healthcare Provider in your area. Precertification of mental health and alcohol/substance use services.	**(800) 626-3643** NON-EMERGENCY CARE 8:30 a.m. to 5:00 p.m. (EST) Monday – Friday EMERGENCY CARE 24 hours a day, 7 days a week
FRAUD HOTLINE	Help prevent health insurance fraud.	**(800) I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. (EST) Monday – Friday

TO CONTACT IN WRITING:

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

How to Use the Plan

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

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

Ways to get the most from your coverage:

Be sure you know what's covered by your plan. That way, you are better able to make decisions about your healthcare. For most covered services, you will have a choice of using In-Network or Out-of-Network Providers.

Choose a Primary Care Physician (PCP). While you must choose a PCP, you do not need a referral to see an In-network or Out-of-Network specialist.

Ask Questions about your healthcare options and coverage. To find answers, you can:

Call Anthem Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply;

Call 24/7 NurseLine – available to you 24 hours a day, seven days a week – to get recorded general health information or to speak to a registered nurse to discuss healthcare issues and more;

Visit us at www.Anthem*.com. Our website features interactive help with customer service representatives.*

CHOOSING IN-NETWORK OR OUT-OF-NETWORK PROVIDERS

The key to using your plan is understanding how benefits are paid. Start by choosing In-Network or Out-of-Network Providers any time you need healthcare. Your choice determines the level of benefits you will receive.

In-Network Services. Your plan offers in-network coverage only for services rendered by In-Network Providers, or by any Providers for emergency care provided by an emergency room or hospital. You have free choice to select any In-Network Provider and there are no claim forms to file for In-Network services. You do not need a referral to see an In-Network Provider specialist. Refer to *Your Benefits At A Glance* section for Copayment information.

Most covered services are available under your plan whether you use In-Network Providers or Out-of-Network Providers.

Refer to Anthem's Directory of Providers to be sure you select In-Network Providers to receive benefits for these services, or log on to Anthem's website at www.Anthem.com and look in Anthem's network for a complete list of In-Network Providers.

Out-of-Network Services are covered healthcare services provided by a licensed Provider outside the POS (or PPO, as applicable) Network. When you use Out-of-Network services:

- Your out-of-pocket costs will be higher;
- You are subject to Deductible and Coinsurance, plus any amount above Anthem's Maximum Allowed Amount;
- You will generally have to pay the Provider when you receive care;
- You will have to file a claim for reimbursement.

How In-Network Benefits Are Paid

In-Network benefits are paid after you pay a Copayment for office visits (including specialist visits) and certain covered outpatient services, such as, x-rays, laboratory services and ambulatory (same day) services.

Out-of-Network Deductible and Coinsurance

Out-of-Network benefits for all covered Out-of-Network services are paid after you meet your individual or family O*ut-of-Network* Deductible for the Benefit Cycle. Once your Out-of-Network Deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called Coinsurance, of Anthem's Maximum Allowed Amount for O*ut-of-Network* services. You are responsible for the cost of any services that are not covered, or for any amount which is in excess of the Maximum Allowed Amount. You pay your *Out-of-Network Deductible and then your Out-of-Network* Coinsurance up to an Out-of-Pocket Maximum for the Benefit Cycle.

Once you meet your *Out-of-Network* out-of-pocket Coinsurance maximum for the Benefit Cycle, you will not be required to pay Coinsurance, but you will still be responsible to pay the difference between the Provider's actual charge and Anthem's Maximum Allowed Amount. This balance billed amount is not credited to the Deductible and maximum Coinsurance payment amounts.

How Deductible and Coinsurance Are Applied for In-Network and Out-of-Network Services

If you have individual coverage:

- Deductible and Coinsurance amounts will be applied for covered Out-of-Network services, until the individual Deductible and Coinsurance are met for the Benefit Cycle.
-

If you have family coverage:

- The individual Deductible and Coinsurance amounts apply to each family member, for covered Out-of-Network services, until the family Deductible and Coinsurance maximums are met per Benefit Cycle. Once the first family member meets the individual Deductible for the Benefit Cycle, that family member will pay Coinsurance up to the individual Coinsurance maximum for the Benefit Cycle. The next family member must also meet the individual Deductible and Coinsurance amounts for the Benefit Cycle. This will apply until the family Deductible and Coinsurance maximums are met for the Benefit Cycle. Once the family Deductible and Coinsurance maximums are met for the Benefit Cycle, the Plan will pay benefits for 100% of covered Out-of-Network services during the remainder of the Benefit Cycle, for all eligible family members (except for Out-of-Network services from non-participating Providers, for which you still pay the difference between the Maximum Allowed Amount and the Providers' charges).

FINDING PROVIDERS AND YOUR PAYMENTS TO THEM

How to locate In-Network Providers

To locate an In-Network Provider, visit www.Anthem.com and *click on "Local Area Provider"*. You can search for Providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the Provider's office. Or, ask your Benefits Administrator to see Anthem's Provider Directory. You can also request that a directory be mailed to you free of charge by calling Anthem Member Services at (844) 243-5566.

Effective January 1, 2022, if you obtain and rely upon incorrect information about whether a Provider is an In-Network Provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the Provider was an Out-of-Network Provider at the time the service was rendered.

Need to See a Specialist?

Your plan allows you to self-refer to any specialist of your choice. To locate a network specialist, check your Provider Directory or visit www.Anthem.com. You may also call Anthem Member Services at **(844) 243-5566**.

The following chart shows specific Plan information. For additional services and for details and definitions of terms, refer to the specific section of this SPD or call Anthem Member Services.

	IN-NETWORK	OUT-OF-NETWORK
COPAYMENT (including Specialist visits) (for office visits and certain covered services)	$20 per visit $20 for Behavioral healthcare visits	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.
COPAYMENT For Urgent Care Center	$20	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.

COPAYMENT For Emergency Room	$100 per visit (waived if admitted to hospital within 24 hours)	
Annual Well-Woman Care Visits	$0	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.
Annual Well-Man Care Visits	$0	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.
Well-Child Care Visits	$0	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.
DEDUCTIBLE per Benefit Cycle (July 1 – June 30)	$0	$1,000/Individual and $2,000/Family
COINSURANCE	$0	After Deductible, you pay 30% of Maximum Allowed Amount. Plan pays 70% of Maximum Allowed Amount.
OUT-OF-POCKET MAXIMUM (OOP) per Benefit Cycle (July 1 – June 30) (includes Deductible, Coinsurance, Copayments)	Medical: $1,500/Individual and $3,000/Family Prescription (Express Scripts): $2,500/Individual and $5,000/family Medical and Prescription	**$2,000**/individual **$4,000/**family of two **$5,000**/family of three or more Maximum Allowed Amount (Deductible included)
LIFETIME MAXIMUM	Unlimited	Unlimited

HELPING YOU MANAGE YOUR HEALTH

Managing your health includes getting the information you need to make informed decisions and making sure you get the maximum benefits the Plan will pay. Anthem's Medical Management program and Anthem Behavioral Health Utilization Management Services work with your Provider to help:

- Confirm the medical necessity of services and help you make sound healthcare decisions.
- Help you manage your health, by precertifying hospital admission and certain treatments and procedures.
- Ensure that you receive access to quality care for the right length of time, in the right setting and with maximum coverage.

To help you manage your health, Anthem provides Medical Management, Case Management, Healthline Nurse Access, and Anthem Behavioral Health Utilization Management Services.

In Anthem's service area, network physicians, hospitals, outpatient facilities, vendors and other network Providers are responsible for calling Anthem's Medical Management Program or Anthem Behavioral Health Utilization Management Services to precertify certain services covered by the Plan.

For services provided out of Anthem's service area, or for services provided by Out-of-Network Providers in the service area, it is **your** responsibility to precertify certain services covered by the Plan.

ANTHEM'S MEDICAL MANAGEMENT PROGRAM

When you call Anthem's Medical Management Program at (800) 982-8089, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- Learn more about your healthcare options.
- Avoid unnecessary hospitalization and the associated risks, whenever possible.
- Choose the most appropriate healthcare setting or service (e.g., hospital or same-day surgery unit).
- Arrange for any required (and covered) discharge services.

To help ensure that you receive quality care, Anthem's Medical Management Program works with you and your Provider to:

- Precertify all planned inpatient and same day surgery admissions and emergency hospital admissions.
- Review ongoing hospitalization.
- Perform individual case management.
- Coordinate discharge planning.
- Precertify outpatient cardiac rehabilitation therapy.

- Precertify inpatient admissions and outpatient services for physical therapy.
- Precertify services for MRIs/MRAs, CAT scans, PET scans and Nuclear Cardiology.
- Coordinate purchase and replacement of durable medical equipment, prosthetics and orthotics.
- Review high risk pregnancies and admissions for illness or injury to newborns.
- Precertify care in a hospice, skilled nursing facility, home healthcare and home infusion therapy.
- Precertify outpatient occupational and speech outpatient therapy services.
- Precertify air ambulance services or within 48 hours after you are admitted or treated at the hospital, or as soon as reasonably possible.

ANTHEM BEHAVIORAL HEALTH UTILIZATION MANAGEMENT SERVICES

When you call Anthem Behavioral Health Utilization Management Services at (800) 626-3643, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- Learn more about your healthcare options.
- Choose the most appropriate healthcare setting or service.

To help ensure that you receive quality care, Anthem Behavioral Health Utilization Management Services works with you and your Provider to:

- Precertify all planned inpatient mental health or substance use services care.
- Review ongoing hospitalization.
- Perform individual case management.
- Coordinate discharge planning.
- Precertify outpatient (including Partial Hospitalization and Intensive Outpatient Program Services) for mental health or substance use services care.

Remember:
***For services provided by an In-Network Provider, precertification is the responsibility of the Network Providers.**
***For services provided by an Out-of-Network Provider, *you* are responsible for obtaining precertification.**

The following chart shows which healthcare services must be precertified with Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services, as applicable, before you receive them.

	WHO CALLS TO PRECERTIFY	
CALL TO PRECERTIFY	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ALL HOSPITAL ADMISSIONS • At least two weeks prior to any planned surgery or hospital admission • At least two weeks prior to all ambulatory surgery • Within 48 hours of an emergency hospital admission, or as soon as reasonably possible • For illness or injury to newborns • Maternity care: within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission • Before you are admitted to a rehabilitation facility, a skilled nursing facility, or hospice care	In-Network Provider	YOU
PREGNANCY • Within the first three months of a pregnancy	In-Network Provider	YOU

BEFORE YOU RECEIVE • Inpatient Care, including, but not limited to, Mental Health Care, Substance Use Services and Alcohol Detoxification • Outpatient Mental Health Care and Substance Use Services • Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs • Transcranial Magnetic Stimulation (TMS) • Occupational, physical, speech and vision therapy • Outpatient/Ambulatory Surgical Treatments (certain procedures) • High tech radiology services: MRI, MRA, PET, CAT, CTA, MRS, CT/PET, SPECT, ECHO Cardiology, Nuclear Technology services • Diagnostics • Outpatient Treatment(s) • WINFertility Treatment(s)	In-Network Provider	YOU
BEFORE YOU • Rent, purchase or replace prosthetics, orthotics or durable medical equipment	In-Network Provider	YOU

IF SERVICES ARE NOT PRECERTIFIED

When you call to precertify services as needed, you will receive maximum benefits. If the admission or procedure is not medically necessary, no benefits will be paid.

Tips for Precertifying Services with Anthem Medical Management or Anthem Behavioral Health Utilization Management Services

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

- Name, birth date and sex;
- Address and telephone number;
- Anthem I.D. card number;
- Name and address of the hospital/facility;
- Name and telephone number of the admitting doctor;
- Reason for admission and nature of the services to be performed.

When the vendor or Provider is required to call Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services for precertification, be sure they know about the precertification requirement and that they have the Anthem Medical Management telephone number (**(800) 982-8089**) or the Anthem Behavioral Health telephone number, (**(800) 626-3643**).

Initial Decisions

Anthem will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services:

- ***Precertification Requests***- Either your PCP/or specialist or you must contact Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services for approval before you receive certain healthcare services. Anthem will review all requests for precertification within three (3) business days of receipt of the necessary information but not to exceed fifteen (15) calendar days from the receipt of the request. If Anthem does not have enough information to make a decision within three (3) business days, Anthem will notify you in writing of the additional information we need, and you and your Provider will have forty-five (45) calendar days to respond. Anthem will make a decision within three (3) business days of our receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.

- ***Urgent Precertification Requests***- If the need for the service is urgent, Anthem will render a decision as soon as possible, taking into account the medical circumstances, but in any event within seventy-two (72) hours of Anthem's receipt of the request. If the request is urgent and Anthem requires further information to make a decision, Anthem will notify you within twenty-four (24) hours of receipt of the request and you and your Provider will have forty-eight (48) hours to respond. Anthem will make a decision within forty-eight (48) hours of its receipt of the requested information, or if no response is received, within forty-right (48) hours after the deadline for a response.

- ***Concurrent Requests***- Concurrent review means that Anthem reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. Anthem will complete all concurrent reviews of services as explained below in the *Medical*

Claims and Appeals section, under the heading "Types of Initial Claims for Benefits and Time Frames for Processing."

- ***Retrospective Requests***- Retrospective review is conducted after you receive medical services. Anthem will complete all retrospective reviews of services already provided within thirty (30) calendar days of our receipt of the claim. If Anthem does not have enough information to make a decision within thirty (30) calendar days, Anthem will notify you in writing of the additional information it needs, and you and your Provider will have forty-five (45) calendar days to respond. Anthem will make a decision within fifteen (15) calendar days of its receipt of the requested information, or if no response is received from the Provider, within fifteen (15) calendar days after the deadline for a response. If Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

If A Request Is Denied

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, or because the service has been determined to be experimental or investigational, Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services will send a notice to you and your doctor in writing with the reasons for the denial. You will have the right to appeal. Refer to the section in this SPD titled *Medical Claims and Appeals* for more information.

If Anthem's Medical Management Program or Anthem's Behavioral Health Utilization Management Services deny benefits for care of services without discussing the decision with your doctor, your doctor is entitled to ask Anthem's Medical Management or Anthem's Behavioral Health Utilization Management Services to reconsider their decision. A response will be provided by telephone and in writing within one (1) business day of making the decision.

CASE MANAGEMENT

If you need additional support for serious illness

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

- Find appropriate, cost-effective healthcare options.
- Reduce medical cost.
- Assure quality medical care.

A Case Manager serves as a single source for patient, Provider, and insurer – assuring that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer
- Stroke
- Chronic illness
- Hemophilia

- AIDS
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Anthem's Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the Plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact Anthem's Medical Management Program at **(800) 982-8089**.

If you would like Case Management assistance for Mental Health Care or Substance Use Services, contact Anthem's Behavioral Health Utilization Management Services at (**800) 626-3643**.

ADDITIONAL HEALTH INSURANCE INFORMATION

Notice Regarding the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the patient and the attending physician, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information on WHCRA benefits, the amount of coverage available to you, and Copayment, Deductible and maximum amounts, please refer to the chart above under "Medical Benefits." You may also contact Anthem for additional information.

Notice Regarding the Newborns' and Mothers' Health Protection Act

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Cesarean section. However, federal law generally does not prohibit the mother's and newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or Anthem for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Patient Protection Rights of the Affordable Care Act

The Plan does not require the designation of a primary care Provider. However, you may wish to choose a primary care Provider who participates in the network and who is available to accept you or your family members. For a list of the participating primary care Providers, contact Anthem or access the Anthem website at www.Anthem.com.

For children, you may choose a pediatrician as the primary care Provider.

You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for

making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem or access the Anthem website at www.Anthem.com.

As noted above, the Plan does not require the selection or designation of a primary care Provider. You have the ability to visit any In-Network or Out-of-Network Health Care Provider; however, payment by the Plan may be less for the use of an Out-of-Network Provider.

APPROVED CLINICAL TRIALS

Covered Expenses include:

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

1. Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

2. Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

An Employee or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

1. Satisfies the protocol prescribed by the Approved Clinical Trial provider; and

   Either:

   The individual's network participating Provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

   The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific

standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Continuity of Coverage

If you are a Continuing Care Patient (see the *Definitions* section), and the In-Network contract with an In-Network Provider or facility is terminated*, or your benefits are terminated because of a change in terms of the Providers' and/or facilities' participation in the Network:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the Provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage at In-Network cost-sharing to allow for a transition of care to an In-Network Provider.

Your Anthem Benefits at a Glance

The following is a brief overview of Anthem's benefits. Please note: there may be some benefits that require precertification. See further information below, as well as the *Helping you Manage Your Health* section for more information about precertification.

	YOU PAY	
HOME, OFFICE, OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
OFFICE VISITS (Primary Care)	$20 Copayment per visit in Office or by Telehealth	Deductible and 30% Coinsurance
SPECIALIST VISITS	$20 Copayment per visit in Office or by Telehealth	Deductible and 30% Coinsurance
CHIROPRACTIC CARE	$20 PCP Copayment per visit	Deductible and 30% Coinsurance
SECOND OR THIRD SURGICAL OPINION	$20 Copayment per visit	Deductible and 30% Coinsurance
DIABETES EDUCATION AND MANAGEMENT	$20 Copayment per visit	Deductible and 30% Coinsurance
ALLERGY CARE • Office Visit	$20 Copayment per visit	Deductible and 30% Coinsurance

* Continuity of coverage will not be approved if the provider leaves the Network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

• Testing • Treatment (i.e., allergy shots)	$0 $0	Deductible and 30% Coinsurance
DIAGNOSTIC PROCEDURES • All lab tests • X-rays and other imaging • MRIs/MRAs • Nuclear cardiology services • PET/CAT scans	$0	Deductible and 30% Coinsurance
SURGERY	$0	Deductible and 30% Coinsurance
ANESTHESIA	$0	Deductible and 30% Coinsurance
INTERRUPTION OF PREGNANCY	See cost-sharing for service rendered	Deductible and 30% Coinsurance
PRE-SURGICAL TESTING	$0	Deductible and 30% Coinsurance
CHEMOTHERAPY & RADIATION THERAPY	$0	Deductible and 30% Coinsurance

	YOU PAY	
HOME, OFFICE, OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
CARDIAC REHABILITATION (outpatient)	$20 Copayment	Deductible and 30% Coinsurance
CARDIAC REHABILITATION (office)	$20 Copayment	Deductible and 30% Coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$20 Copayment per visit	Deductible and 30% Coinsurance
X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	Deductible and 30% Coinsurance
KIDNEY DIALYSIS	$0	Deductible and 30% Coinsurance
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK

(services subject to change; see *Preventive Services* section for more information)		
ADULT ANNUAL PHYSICAL OFFICE EXAM • One per calendar year	$0	Deductible and 30% Coinsurance
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 calendar years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per calendar year – Sigmoidoscopy if age 40 or over: 1 every 2 calendar years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Age 50 and over: 1 per calendar year – Between age 40-49 if risk factors exist: 1 per calendar year – If prior history of prostate cancer, 1 PSA per calendar year at any age • Diagnostic PSA: 1 per calendar year	$0 $0 $0 $0 $0	Deductible and 30% Coinsurance
WELL-WOMAN CARE • Office visits (PCP co-pay for OB/GYN) • Outpatient visit • Pap smears • Bone Density testing and treatment (precertification required for Bone Density testing) • Mammogram (based on age and medical history) Ages 35 through 39 – 1 baseline Age 40 and older – 1 per calendar year • Women's sterilization procedures and counseling • Breastfeeding support, supplies and counseling – One breast pump per pregnancy	$0 $0 $0 $0 $0 $0 $0 $0	Deductible and 30% Coinsurance

• Screenings and/or counseling for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune deficiency (HIV), interpersonal and domestic violence		

WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits – Newborn: 2 in-hospital exams at birth following vaginal delivery – Newborn: 4 in-hospital exams at birth following C-section delivery • Office visits – From birth up to age 1: 7 visits – Ages 1 through 4: 7 visits – Ages 5 through 11: 7 visits – Ages 12 through 17: 6 visits – Ages 18 to 21st birthday: 2 visits • Lab tests ordered at the well-child visits and performed in the office or in the laboratory • Certain immunizations (office visits are not required)	$0 $0 $0 $0	Deductible and 30% Coinsurance
EMERGENCY CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Centers	$20	Not covered (In-Network only)
EMERGENCY ROOM	$100 per visit Copayment (waived if admitted to the same hospital within 24 hours)	
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	$0	$0

EMERGENCY AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the Maximum Allowed Amount; you pay the difference between the Maximum Allowed Amount and the total charge.	Deductible and 30% Coinsurance
MATERNITY CARE AND REPRODUCTIVE SERVICES	IN-NETWORK	OUT-OF-NETWORK
PRENATAL AND POSTNATAL CARE (in doctor's office)	$20 Copayment for first visit only (no Copayments for subsequent visits)	Deductible and 30% Coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES (in office)	$0	Deductible and 30% Coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0	Deductible and 30% Coinsurance
OBSTETRICAL CARE (in hospital or birthing center*)	$0	Deductible and 30% Coinsurance *Out-of-Network birthing centers are not Covered
INFERTILITY TREATMENT	$0	Deductible and 30% Coinsurance
ADVANCED REPRODUCTIVE TECHNOLOGIES	$0	Deductible and 30% Coinsurance

	YOU PAY	
HOSPITAL SERVICES*	IN-NETWORK	OUT-OF-NETWORK
SEMI-PRIVATE ROOM AND BOARD GENERAL, SPECIAL AND CRITICAL NURSING CARE INTENSIVE CARE	$0	Deductible and 30% Coinsurance

* Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation.

SERVICES OF LICENSED PHYSICIANS AND SURGEONS SURGERY (Inpatient and Outpatient)** SURGICAL ASSISTANT OXYGEN ANESTHESIA		
BLOOD, BLOOD PRODUCTS & BLOOD DERIVATIVES & SERVICES	$0	Deductible and 30% Coinsurance
CHEMOTHERAPY & RADIATION THERAPY	$0	Deductible and 30% Coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	Deductible and 30% Coinsurance
DRUGS AND MEDICATIONS	$0	Deductible and 30% Coinsurance
DRESSINGS	$0	Deductible and 30% Coinsurance
X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	Deductible and 30% Coinsurance
KIDNEY DIALYSIS	$0	Deductible and 30% Coinsurance

** For a second procedure performed during an authorized surgery through the same incision, Anthem pays for the procedure with the higher Maximum Allowed Amount. For a second procedure done through a separate incision, Anthem will pay the Maximum Allowed Amount for the procedure with the higher allowance and up to 50% of the Maximum Allowed Amount for the other procedure.

	YOU PAY	
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	IN-NETWORK	OUT-OF-NETWORK
DURABLE MEDICAL EQUIPMENT (i.e., hospital-type bed, wheelchair, sleep apnea monitor)	$0	In-Network only
ORTHOTICS	$0	In-Network only
PROSTHETICS (i.e., artificial arms, legs, eyes, ears) Includes lenses and/or glasses after cataract surgery	$0	In-Network only
MEDICAL SUPPLIES (i.e., catheters, oxygen, syringes)	$0	In-Network only
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	$0	Deductible and 30% Coinsurance
SKILLED NURSING AND HOSPICE CARE	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY Up to sixty (60) days per calendar year Precertification required	$0	Deductible and 30% Coinsurance
HOSPICE Up to two hundred ten (210) days per lifetime	$0	Deductible and 30% Coinsurance
HOME HEALTHCARE	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTHCARE Up to two hundred (200) visits per calendar year (a visit equals four (4) hours of care) *	$0	30% Coinsurance only. No Deductible
HOME INFUSION THERAPY	$0	30% Coinsurance only. No Deductible.
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	IN-NETWORK	OUT-OF-NETWORK
PHYSICAL THERAPY AND REHABILITATION	$0	

* Treatment maximums are combined for In-Network and Out-of-Network care.

• Up to thirty (30) visits combined in home, office, inpatient or outpatient facility per calendar year* • Precertification required for inpatient admissions		Deductible and 30% Coinsurance
OCCUPATIONAL, SPEECH, VISION THERAPY • Up to thirty (30) visits combined in home, office or outpatient facility per calendar year • Precertification required	$20 Copayment per visit	Deductible and 30% Coinsurance

* Treatment maximums are combined for In-Network and Out-of-Network care.

	YOU PAY	
BEHAVIORAL HEALTHCARE	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT (including Partial Hospitalization and Intensive Outpatient Program Services) • Unlimited number of medically necessary visits • Must be precertified; Anthem Behavioral Health, (800) 626-3643	**Outpatient Facility** $0 **Outpatient Office Visit** $20 Copayment in Office or by Telehealth	Deductible and 30% Coinsurance
INPATIENT MENTAL HEALTH CARE for a continuous confinement when in a Hospital (including Residential Treatment) • Unlimited number of medically necessary days • Unlimited number of medically necessary visits from mental healthcare professionals • Must be precertified; Anthem Behavioral Health, (800) 626-3643	$0 $0	Deductible and 30% Coinsurance Deductible and 30% Coinsurance
ALCOHOL OR SUBSTANCE USE SERVICES	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT (including Partial Hospitalization and Intensive Outpatient Program Services) • Unlimited number of medically necessary visits, including visits for family counseling • Must be precertified; Anthem Behavioral Health, (800) 626-3643	**Outpatient Facility** $0 **Outpatient Office Visit** $20 Copayment in Office or by Telehealth	Deductible and 30% Coinsurance
INPATIENT SUBSTANCE USE SERVICES for a continuous confinement when in a Hospital (including Residential Treatment) • Unlimited number of medically necessary days of detoxification • Unlimited number of medically necessary rehabilitation days • Must be precertified; Anthem Behavioral Health, (800) 626-3643	$0 $0	Deductible and 30% Coinsurance Deductible and 30% Coinsurance

GENDER AFFIRMING CARE

The Plan provides medically-necessary gender affirming care benefits in accordance with this SPD. Such medically-necessary benefits may include, but are not limited to, Mental Health Care Benefits, Prescription Drug Benefits, and Medical Benefits.

PREVENTIVE SERVICES

Please refer to the *Your Anthem Benefits at a Glance* section for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Preventive Services. The Plan Covers the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed In-Network by an In-Network Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee In Immunization Practices ("ACIP").

However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Anthem at the number on your ID card or visit Anthem's website at www.Anthem.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

Preventive services received from an Out-of-Network Provider will not be eligible for coverage under this Preventive Services benefit unless there is no Provider in the Plan's network who can provide the particular service.

If there is a question as to whether a particular benefit is a "preventive service" under the federal guidelines, the Trustees will determine whether the benefit is covered is a "Preventive Service."

Covered Preventive Services for Adults, Women, including Pregnant Women, and Children are listed below. However, covered care and services are subject to change as preventive care guidelines and recommendations are updated or modified. For a current list of preventive care and services, visit https://www.healthcare.gov/coverage/preventive-care-benefits/, www.Anthem.com, or contact Anthem.

Covered Preventive Services

Well-Baby and Well-Child Care. The Plan Covers well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits listed in the *Your Anthem Benefits at a Glance* section permits one (1) well-child visit per Calendar Year, the Plan will not deny a well-child visit if 365 days have not passed since the previous well-child visit. This benefit is provided to Members from birth through attainment of age 21 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Immunizations and boosters as recommended by ACIP are also Covered. Current ACIP-recommended vaccines are:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Whooping cough

Adult Annual Physical Examinations. The Plan Covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the Covered Preventive Services is available on Anthem’s website at www.Anthem.com, or will be mailed to you upon request.

You are eligible for a physical examination once every Calendar Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by an In-Network Provider.

Adult Immunizations. The Plan Covers adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by an In-Network Provider. Current ACIP-recommended vaccines are:

- Diphtheria/tetanus/pertussis (whooping cough)
- Measles/mumps/rubella (MMR)
- Influenza (flu)
- Human papillomavirus (HPV)
- Pneumococcal (pneumonia)
- Zoster (shingles)
- Hepatitis A

- Hepatitis B
- Meningococcal (meningitis)
- Varicella
- Monkeypox and/or smallpox (at risk)
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)

Well-Woman Examinations. The Plan Covers well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Anthem's website at www.Anthem.com, or will be mailed to you upon request.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, and when provided by an In-Network Provider.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. The Plan Covers mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Plan Covers mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Calendar Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Family Planning and Reproductive Health Services. The Plan Covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Plan's Prescription Drug Benefits; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by an In-Network Provider.

Note: the Plan also Covers vasectomies subject to Cost-Sharing (i.e., Copayments, Deductibles or Coinsurance).

Bone Mineral Density Measurements or Testing. The Plan Covers bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Plan's Prescription Drug Benefits. Precertification is required for Bone Density testing. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

The Plan also covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by an In-Network Provider and in accordance with the HRSA guidelines supported by HRSA and items or services with an A or B rating from USPSTF.

Screening for Prostate Cancer. The Plan Covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen ("PSA") test for men age 50 and over who are asymptomatic, one per calendar year. For men between ages 40 and 49 with a family history of prostate cancer or other prostate cancer risk factors, one PSA per calendar year. For men with a prior history of prostate cancer, one PSA per calendar year at any age. The Plan also Covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer, and one diagnostic PSA per calendar year.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by an In-Network Provider.

EMERGENCY CARE

Non-Emergency Ambulance Transportation Between Facilities

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

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

Limitations/Terms of Coverage

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

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

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

- The point of pick-up is inaccessible by land vehicle; or

- Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Emergency Air Ambulance

The Plan will provide coverage for air ambulance which is authorized by Anthem's Medical Management Program to transport you to the nearest acute care hospital in connection with emergency room care or emergency inpatient admission or emergency room care.

If You Need Urgent Care

Urgent care is care required in order to prevent serious deterioration to your health. It is the type of care that requires timely attention (i.e., bronchitis, high fever, sprained ankle), but it is not an emergency. Urgent care is covered in an urgent care center or in your physician's office.

If you need urgent care or after-hours care, call your PCP or your PCP's backup. Your PCP is required to have coverage 24 hours a day, seven days a week so you have access to urgent care. You can also call the 24/7 NurseLine for advice from a registered nurse at **(877) TALK-2RN ((877) 825-5276),** 24 hours a day, seven days a week.

If you visit an in-network doctor or urgent care center, you pay a Copayment for the visit. If you visit an Out-of-Network doctor or urgent care center, you pay an Out-of-Network Deductible and Coinsurance and any amount above Anthem's Maximum Allowed Amount (if the care is received from a BlueCard Provider, you do not pay any amount above the Maximum Allowed Amount).

Urgent Care is typically available after normal business hours, including evenings and weekends. If you need care after normal business hours, including evenings, weekends or holidays, you have options. You can call your Provider's office for instructions or visit an Urgent Care Center. If you have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

Compliance with the No Surprises Act ("NSA")

Emergency Services

The Plan provides coverage of Emergency Services as required by the NSA as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care Provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;

4. Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your Deductible and Out-of-Pocket Maximum in the same manner as those received from an In-Network Provider.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

The Plan provides coverage of Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility as required by the NSA as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any Deductible and Out-of-Pocket Maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

1. At least seventy-two (72) hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

2. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Please refer to the *Helping you Manage your Health* section for details regarding precertification requirements.

The notice and consent exception does not apply to Ancillary Services (see the *Definitions* section of this SPD) and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Emergency Air Ambulance

The Plan provides coverage for air ambulance which is authorized by Anthem's Medical Management Program to transport you to the nearest acute care hospital in connection with emergency room care or emergency inpatient admission or emergency room care.

As required by the NSA, if you receive air ambulance services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

1. The air ambulance services received from an Out-of-Network Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing

requirement that would apply if the services had been furnished by an In-Network Provider.

2. In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network Provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

3. Any cost-sharing payments you make with respect to covered air ambulance services will count toward your In-Network Deductible and In-Network Out-of-Pocket Maximum in the same manner as those received from an In-Network Provider.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the NSA, you may contact the federal government's NSA Helpdesk at (800) 985-3059 or the Employee Benefits Security Administration ("EBSA") toll free number at (866) 444-3272. If you have a question about an explanation of benefits issued by the Plan, you may contact the Benefits Office at (212) 356-8180.

External Review Process of Certain Coverage Determinations

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network Provider at an In-Network facility, and/or air ambulance service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Benefits Office for a copy of the Plan's External Review procedures.

MATERNITY CARE

If You Are Having A Baby

When you use In-Network Providers for maternity care, no Copayments apply to maternity office visits after the first visit, where you will be responsible for a $20 Copayment.

What's Covered

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

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

Refer to the *Your Benefits At A Glance* section for a snapshot about out-of-network Deductible and Coinsurance amounts and In-network and out-of-network plan maximums.

For out-of-network maternity services, you pay the Deductible, Coinsurance and any amount above the Maximum Allowed Amount. Anthem's reimbursements for the remaining balance may be consolidated in up to three installments, as follows:

- Two payments for prenatal care
- One payment for delivery and post-natal care

Please refer to the *Helping you Manage your Health* section for details regarding precertification requirements.

What's Not Covered

- Days in hospital that are not medically necessary (beyond the 48 hour/96 hour limits)
- Services that are not medically necessary
- Private room
- Private duty nursing

BUILDING HEALTHY FAMILIES

Building Healthy Families is a free program through Anthem that can help pregnant women have a healthy baby. You are eligible for the program if you are a covered Employee or spouse under the Plan. It's easy to join, call Anthem toll free at (800) 828-5891.

The following is available to you when you sign up:

- A toll-free number you can use to talk to a maternity nurse coach anytime, any day.
- A maternity diary packed with tips for a healthy pregnancy and notes for your doctor visits.
- A book to show you what changes you can expect over the next nine months.
- A health assessment to make sure you and your baby stay as healthy as possible.
- Free phone calls with specialists, such as dietitians and lactation consultants as needed.
- A screening to check your health risk for depression or early delivery.
- Other helpful information on labor and delivery.

BEHAVIORAL HEALTHCARE

Mental Healthcare

What's Covered

In addition to the services listed in *Your Benefits At A Glance* section, the following mental healthcare service is covered:

Care from psychiatrists, psychologists, nurse practitioners or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

Electroconvulsive therapy for treatment of mental or behavioral disorders.

Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.

Applied Behavioral Analysis ("ABA") therapy for autism spectrum disorder.

Please refer to the *Helping You Manage Your Health* section for details regarding precertification requirements.

Treatment for Alcohol or Substance Use

What's Covered

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

Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive medically necessary counseling visits.

Out-of-network outpatient treatment at a facility that:

Has New York State certification from the Office of Addiction Services and Supports

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

What's Not Covered

Care that is not medically necessary.

Please refer to the *Helping You Manage Your Health* section for details regarding precertification requirements.

EXCLUSIONS AND LIMITATIONS

Exclusions

In addition to services mentioned under *What's Not Covered* in the prior sections, the Plan's Medical Benefits do not cover the following:

Bariatric Surgery

Hospitalization or treatment for bariatric surgery, except where Medically Necessary for the treatment of eating disorders.

Cosmetic Surgery

Hospitalization or treatment for elective cosmetic surgery.

Custodial Care Exclusions

Care or services which are custodial in nature, including assistance in activities of daily living such as bathing, feeding or changing; or services that do not require performance by skilled personnel.

Dental Services Exclusions

Dental services, including but not limited to:

- Cavities and extractions
- Care of gums
- Bones supporting the teeth or periodontal abscess
- Orthodontia
- False teeth
- Treatment of TMJ that is dental in nature
- Orthognathic surgery that is dental in nature

Please see the *Dental Benefits* section for benefits provided by Guardian.

Dental Services Limitations

However, your Plan does cover:

- Surgical removal of impacted teeth
- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury
- Dental care or treatment necessary due to congenital disease or anomaly

Experimental/Investigational Treatments Exclusions

Technology, treatments, procedures, drugs, biological products or medical devices that in Anthem's judgment are:

- Experimental or investigative
- Obsolete or ineffective

Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:

- Not of proven benefit.
- Not generally recognized by the medical community (as reflected in published medical literature).

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

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

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state.

Fraud, Waste, Abuse, and Other Inappropriate Billing.

We do not cover services from an Out-of-Network Provider that are determined to be not payable as a result fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

Government Hospital Services Exclusions

Services covered under government programs, except Medicaid or where otherwise noted.

Government hospital services, except:

- Specific services covered in a special agreement between Anthem and a government hospital.

- United States Veteran's Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Anthem will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

Hearing Aid Exclusion

Anthem does not provide hearing aid coverage. Please see the *Hearing Aid Benefit* section for more information about the Plan's coverage of hearing aids.

Home Care Limitation

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

Inappropriate Billing Exclusion

Services usually given without charge, even if charges are billed.

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

Medically Unnecessary Services Exclusion

Services, treatment or supplies not medically necessary in Anthem's judgment. See the *Definitions* section for more information.

Prescription Drugs Exclusion

Anthem does not provide prescription drug coverage. Please see the *Prescription Drug Benefits* section for more information about the Plan's prescription drug coverage and exclusions.

Services Provided Pursuant to a Prohibited Referral Exclusion

We will not pay for pharmacy services, clinical laboratory services, or x-ray or imaging services furnished by any Provider pursuant to a referral prohibited by §238-a of the New York State Public Health Law. Generally, §238-a prohibits physicians and other healthcare practitioners from making referrals for pharmacy services, clinical laboratory services or x-ray and imaging services to a Provider or facility in which the referring physician or practitioner or an immediate family member has a financial interest or relationship.

Sterilization Exclusion

Reversal of elective sterilization, including vasectomies and tubal ligations.

Travel Exclusion

Travel, even if associated with treatment and recommended by a doctor.

Vision Care Limitation

Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated.

War Exclusion

Services for illness or injury received as a result of war.

Weight Loss Program Exclusion

Weight Loss Programs, except where such programs are medically-necessary Preventive Services. See the *Preventive Services* section for more information.

Workers' Compensation Exclusion

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

Limitation as independent contractor

The relationship between Anthem Blue Cross Blue Shield and hospitals, facilities or providers is that of independent contractors. Nothing in this contract shall be deemed to create between Anthem and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Anthem will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

DEFINITIONS

Refer to these definitions to help you better understand your coverage.

Need more help? Additional terms and definitions can be viewed at www.Anthem.com.

Adverse Determination

A communication from Anthem's Medical Management that reduces or denies benefits.

Ambulatory Surgery

See "same-day surgery."

Ancillary Services

With respect to an In-Network Health Care Facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Items and services provided by an Out of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

Authorized Services

See "precertified services."

Benefit Cycle

The Benefit Cycle begins July 1 and ends June 30.

Continuing Care Patient

An individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition;" (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the Provider or facility.

Copayment

The fee you pay for office visits and certain covered services when you use In-Network providers. The Plan then pays 100% of remaining covered expenses.

Covered Services

The services for which Anthem provides benefits under the terms of the contract between the Plan and Anthem.

Custodial Care

Custodial care means care which we determine is designed chiefly to assist a person to meet their activities of daily living as defined by Medicare. Such care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled nursing care. Anthem will not pay for care we determine is custodial care.

Deductible

The dollar amount you must pay each calendar year before the Plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, the Plan will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit – if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

Emergency Medical Condition

A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

Emergency Services

Includes the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department (some urgent care facilities, but not all, qualify), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical

examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized)) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

    a. The Provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

    b. You are supplied with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

    c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Facility

A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Health Law Article 30; and a Facility defined in New York Mental Hygiene Law Sections 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health and participates with Anthem or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral healthcare purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Anthem to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be

certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

For certain specified benefits, the definition of a "hospital" or "facility" may include a hospital, hospital department or facility that has a special agreement with Anthem.

Anthem does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted on previous page); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.

Health Care Facility

For Non-Emergency Services, each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Health Care Professional

An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analysis; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Plan.

Home Healthcare

Skilled nursing care and related services performed in the patient's home by a home health agency.

Hospice

A program that provides medical and supportive care (including pain relief) for terminally ill patients (life expectancy of six months or less). Hospice care includes bereavement counseling for the patient's family.

In-Network Benefits

Benefits for covered services delivered by In-Network Providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Cost-Sharing

Amounts You must pay to an In-Network Provider for Covered Services, expressed as Copayments, Deductible and/or Coinsurance.

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home healthcare or home infusion supplier who is in the POS or PPO Networks.

Itemized Bill

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

Maximum Allowed Amount (MAA)

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

Medically Necessary

We cover benefits described in this SPD as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or means that the Plan has to cover it.

The Plan may base its decision on a review of:

- Your medical records;
- The Plan's medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;

- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service of sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;

When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office of the home setting.

Network

The Providers Anthem has contracted with to provide health care services to You.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Anthem or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Anthem's DirectShare^{SM} POS or PPO contracts.

No Surprises Services

To the extent covered under the Plan, "No Surprise Services" includes the following:

1. Out-of-Network Emergency Services;

2. Out-of-Network air ambulance services;

3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and

4. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility with respect to which the Provider does not comply with federal notice and consent requirements.

Out-of-Pocket Maximum

The most you pay during a Benefit Cycle in cost sharing (Deductible, Coinsurance, and Copayments) before the Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Out-of-Pocket Maximum does not include amounts over the Maximum Allowed Amount or charges for services that the Plan does not cover. Please see the *Your Benefits At A Glance* section for cost shares that apply.

Out-of-Network Benefits

Reimbursement for covered services provided by Out-of-Network Providers and suppliers. Out-of-Network benefits are generally subject to a Deductible and Coinsurance and any amounts above the Maximum Allowed Amount, and therefore, have higher out-of-pocket costs. When you use a BlueCard Program provider, you do not pay any amounts over the Maximum Allowed Amount.

Out-of-Network Cost-Sharing (Deductible and Coinsurance)

Amounts you must pay to an Out-of-Network Provider for Covered Services. Out-of-Network benefits for all services are paid after you meet an individual or family Out-of-Network Deductible. Once your Out-of-Network Deductible is met, you and the Plan share the cost. You and the Plan each pay a percentage, called Coinsurance, of Anthem's Maximum Allowed Amount for the Out-of-Network service. You are responsible for any amounts not covered, or which are in excess of the Maximum Allowed Amount. You pay your Out-of-Network Coinsurance up to an annual Out-of-Pocket Maximum. Once you meet your annual Out-of-Network Out-of-Pocket Coinsurance Maximum, you will not be required to pay Coinsurance, but you will be responsible to pay the difference between the provider's actual charge and Anthem's Maximum Allowed Amount. This is not applied to the Deductible and Coinsurance amounts. Refer to *Your Benefits at a Glance* section for your Out-of-Network Deductible, Coinsurance and Out-of-Pocket Maximum amounts.

For Out-of-Network services, if you have family coverage, once the first family member meets the individual Deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two (2) or more eligible family members meet the family Deductible. Once the family Deductible is met, the Plan will pay benefits for covered services during the remainder of the Benefit Cycle for all eligible family members.

Out-of-Network Providers/Suppliers

A doctor, other professional provider, or durable medical equipment, home healthcare or home infusion supplier who is not in the POS (or PPO, as applicable) Network.

Outpatient Surgery

See "same-day surgery."

Out-of-Pocket Maximum

The most you pay during a Benefit Cycle in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Out-of-Pocket Maximum does not include your employee contributions (if any), amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Out-of-Pocket Maximum may consist of Deductibles, Coinsurance, and/or Copayments. Please see the *Your Benefits At A Glance* section for cost shares that apply to this Plan.

Participating Hospital/Facility

A hospital or facility that is in the POS (or PPO, as applicable) Network.

Plan Administrator

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. To identify your Plan Administrator, contact your employer or health plan sponsor.

Precertified Services

Services that must be coordinated and approved by Anthem's Medical Management or Behavioral Healthcare Management Programs to be fully covered by this Plan. Failure to precertify may result in a reduction or denial of benefits.

Provider

A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Anthem will pay benefits only for covered services within the scope of the practitioner's license.

For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists, licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Qualifying Payment Amount (QPA)

Generally, the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

Recognized Amount

One of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the QPA.

For air ambulance services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the Provider or facility or the QPA.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital. Same-day or outpatient surgery is surgery performed in a hospital or other facility that does not require an overnight stay. For same-day surgery, the definition of "hospital" may include a free-standing ambulatory surgical facility that has a participation agreement with either Anthem or another Blue Cross and/or Blue Shield plan. "Facility" does not include a provider's office.

Serious and Complex Condition

One of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent; or

2. In the case of a chronic illness or condition, a condition that is the following:

   a. Life threatening, degenerative, potentially disabling, or congenital; and

   b. Requires specialized medical care over a prolonged period of time.

Specialty Care Center

A facility accredited or designated by a State agency or by a voluntary national health organization having special expertise in treating a specified condition or disease. Examples include, but are not limited to: centers for HIV/AIDS (designated by the New York State AIDS Institute), cerebral palsy (accredited by the New York State Department of Health), cystic fibrosis (designated by the Cystic Fibrosis Foundation), cancer (accredited by the National Cancer Institute, organ transplants

(accredited by Medicare), hemophilia (designated by the National Hemophilia Foundation), multiple sclerosis (designated by the National Multiple Sclerosis Society), and sickle cell disease (accredited by the National Institute on Health).

Treatment Maximums

Maximum number of treatments or visits for certain conditions. Maximums for In-Network and Out-of-Network services are combined. For example, if the Plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits In-Network and 13 visits Out-of-Network.

MEDICAL CLAIMS AND APPEALS

Claims

If you receive services from an In-Network provider, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received Out-of-Network, from a non-participating provider.

- Visit www.Anthem.com, click on Customer Support, and scroll down to the claim section and click the link titled "Health Insurance Claim Form (Member Submitted) Downstate" and print out a claim form immediately or contact Anthem Member Services at (800) 553-9603 Monday to Friday 9 am to 5 pm and listen to the prompts for customer service.
- File claims within 90 days of date of service.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts; photocopies will not be accepted and should be kept for your records.
- If Anthem is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

Send your Anthem (hospital, surgical or medical) claims forms to:

Hospital Claims:

Anthem Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department

Medical/Surgical Claims:

Anthem Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Department

<u>Types of Initial Claims for Benefits and Time Frames for Processing</u>

The following describes how your claims are classified, which in turn determines how they will be processed. Depending on the type of claim, it will be processed within the time frames set out below:

- **Pre-Service Claim**

A Pre-Service Claim means any claim for a benefit under this Plan in which the Plan requires receipt of the benefit in whole or in part, on approval in advance of obtaining medical care. There are, for example, claims subject to precertification or pre-authorization. Please refer to the specific service to be provided to determine if pre-approval is required. Pre-Service Claims have the following time frames:

-Notification to claimant of benefit determination in writing within: 15 days
-Extension for matters beyond the control of the Plan within: 15 days

If you have not provided sufficient information regarding your claim:

-You will receive notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim within: 5 days
-You must respond within: 45 days

- **Concurrent/Ongoing Treatment Claim**

A Concurrent/Ongoing Treatment Claim means any approved and ongoing course of treatment to be provided over a period of time or number of treatments. Concurrent claims have the following time frames:

-Reduction or termination before the end of the treatment within: 15 days
-Request to extend course of treatment within: 15 days

In the case of a Concurrent/Ongoing course of treatment involving Urgent Care, the following timetable applies for notification in writing to claimant:

-Reduction or termination before the end of treatment within: 72 hours
-Determination as to extending course of treatment within (if request to extend made at least 24 hours prior to expiration of course of treatment): 24 hours
-Determination as to extending course of treatment within (if request to extend made less than 24 hours prior to expiration of course of treatment): 72 hours

- **Urgent/Expedited Claim**

A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. Urgent/Expedited Claims have the following time frames:

-Notification to claimant of benefit determination within: 72 hours

If you have not provided sufficient information regarding your claim:

-You will receive notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim within: 24 hours
-You must respond, orally or in writing, within: 48 hours
-Notification to claimant of benefit determination, orally or in writing, within: 48 hours

- **Post-Service Claim**

A Post-Service Claim means any claim for a Plan benefit that is not a claim involving a Pre-Service Claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant. Post-Service Claims have the following time frames:

-Notification to claimant of benefit determination within:	30 days
-Extension due to matters beyond the control of the Plan:	15 days

If you have not provided sufficient information regarding your claim:

-Notification of failure to follow the Plan's procedures for filing a Claim within:	15 days
-You must respond within:	45 days

Appeals

To initiate an Internal Appeal (whether Level 1, Expedited Level 1, or Voluntary Level 2), the following information must be submitted (see further information below regarding how to file):

- your name, contact information, and Member ID number;
- the service or supply for which benefit coverage has been denied;
- the date(s) of the medical service and provider's name;
- the specific medical condition or symptom;
- a brief description of why you disagree with the denial; and
- any additional information that may be relevant to the appeal, including provider statements/letters, bills or any other documents.

- **Internal Level 1 Appeals**

An Internal Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date on your Explanation of Benefits to file an appeal. An appeal submitted beyond the 180-calendar-day limit may not be accepted for review.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

For Internal Level 1 Appeals for Medical Benefits, write to:

Anthem HealthChoice Assurance, Inc.
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services

For Internal Level 1 Appeals for Behavioral Healthcare, call (800) 635-6626 or write to:

Anthem Blue Cross Blue Shield
Grievance and Appeals
P.O. Box 2100
North Haven, CT 06473
Attention: Behavioral Healthcare Program

- **Expedited Internal Level 1 Appeals**

You can file an ***expedited*** Internal Level 1 Appeal and receive a quicker response if:

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

Please note that appeals of claims decisions made after the service has been provided cannot be expedited.

Expedited Internal Level 1 Appeals May Be Filed by Telephone and in Writing. To file an Expedited Internal Level 1 Appeal, call the phone number on Anthem's initial denial letter or call (203) 677-9100. When you file an expedited appeal, Anthem will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

Time Frames for Processing Level 1 Appeals

Anthem will make a decision on your Internal Level 1 Appeal within the following timeframes:

- **Pre-Service Claim Appeal:** Notification in writing within 30 days.
- **Urgent/Expedited Claim Appeal:** Notification in writing within 72 hours.
- **Post-Service Claim Appeal:** Notification in writing within 60 days.

- **Voluntary Internal Level 2 Appeals**

If you are dissatisfied with the outcome of your Internal Level 1 Appeal, you can file a Voluntary Internal Level 2 Appeal with Anthem. The Voluntary Internal Level 2 Appeal must be filed within 60 days of the date of the Internal Level 1 Appeal decision. An appeal submitted beyond the 60-calendar-day limit may not be accepted for review.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

Voluntary Internal Level 2 Appeals for Medical Benefits, write to:

Anthem HealthChoice Assurance, Inc.
P.O. Box 1407

Church Street Station
New York, NY 10008-1407
Attention: Member Services

Voluntary Internal Level 2 Appeals for Behavioral Healthcare, call (800) 635-6626 or write to:

Anthem Blue Cross Blue Shield
Grievance and Appeals
P.O. Box 2100
North Haven, CT 06473
Attention: Behavioral Healthcare Program

Anthem will make a decision on your Voluntary Internal Level 2 Appeal in a reasonable amount of time.

In some cases, you may also request an Independent External Review as detailed immediately below.

- **Independent External Review**

If the outcome of the mandatory Internal Level 1 Appeal is adverse to you, and it was based on medical judgment, pertained to a rescission of coverage, a determination that care was experimental or investigational, or involved consideration of whether the Plan complied with the surprise billing or cost-sharing protections of the NSA, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of the final internal adverse determination of your Internal Level 1 Appeal. Please note that if you file a request for External Review, you will not be able to file a request for a Voluntary Internal Second Level Appeal.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;

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

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Requesting External Review is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent External Review. However, the External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

No lawsuit shall be brought to recover benefits under the Plan unless you have exhausted the appeals procedure outlined above. Please note that if you file a request for External Review or a Voluntary Internal Second Level Appeal, you may not commence any lawsuit until you receive a final decision.

WINFERTILITY BENEFIT

WINFertility services are covered up to three (3) cycles of In-Vitro Fertilization (IVF) or Egg Retrieval per lifetime maximum under the provisions of the Plan. This benefit is for Eligible Covered Participants who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. The services must be precertified by calling Anthem's Medical Management Program at least two weeks prior to the initiation of hormone treatment services. Failure to obtain precertification of services will result in a denial of benefits.

1. The following procedures are covered:

    a. Artificial Insemination (including intrauterine insemination IUI) and Timed Intercourse (TI) cycles; stimulated with ovulatory stimulants (e.g., Clomid) or aromatase inhibitors (e.g., Letrozole) or completed without stimulation medications.

    b. Advanced reproductive technologies:

        i. In-Vitro Fertilization (IVF)

        ii. Frozen Embryo Transfer (FET) (including use of donor embryos)

        iii. Oocyte Thaw Cycles (OTC) (including use of donor eggs)

        iv. Zygote Intrafallopian Transfer (ZIFT)

        v. Gamete Intrafallopian Transfer (GIFT)

        vi. Intracytoplasmic Sperm Injection (ICSI)

    c. Medically necessary and appropriate diagnostic workup and radiology services.

    d. Pathology and laboratory services, including:

        i. Hormonal assays

        ii. Swimup semen analysis, as appropriate

        iii. Ultrasound exams

        iv. Fertilization and embryo culture

        v. Ova retrieval

        vi. Assisted Hatching

        vii. Embryo Biopsy for Preimplantation Genetic Testing (PGT), Preimplantation Genetic Diagnosis (PGD) and Preimplantation Genetic Screening (PGS) per Anthem Medical Guidelines.

viii. Cryopreservation for the following:

A. Blastocyst(s) and embryo(s) from covered IVF cycles and Oocyte Thaw cycles with storage for up to one (1) year beginning from the initial date of cryopreservation.

B. Oocyte(s) and sperm when a medical treatment will directly or indirectly lead to iatrogenic infertility with storage for up to one (1) year beginning from the initial date of cryopreservation.

C. The Plan does not pay for cryopreservation beyond one (1) year from the initial date; for storage beyond one (1) year, you will need to contact your physician and/or the Cryopreservation Facility to arrange for direct pay.

2. Medications necessary to the provision above, including parenteral injection and oral ovulation induction drugs in accordance with prescription drug benefit limits for infertility treatment-related drugs while the member is a member of this Plan.

3. All frozen embryos (or all euploid frozen embryos, if PGS was performed) stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle for IVF when clinically appropriate. Embryo transfer guidelines per the American Society of Reproductive Medicine (ASRM) should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

4. The following are not covered:

   a. Expenses for procuring donated oocytes, sperm, or embryos, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g., suppression medications, stimulation medications).

   b. Gonadotropin or menotropin stimulated ovulation induction cycles including monitoring of Timed Intercourse and IUI cycles unless member has a diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism, or after member has not ovulated or conceived after a prior trial of 3 cycles or clomiphene citrate or letrozole.

   c. Fallopian tube ligations and vasectomy reversals. If a member or the member's partner has undergone an elective sterilization procedure, they are not eligible for benefits unless they undergo a successful reversal and thereafter met DOI; or WIN’s consulting medical director determines that the reversal of the elective sterilization procedure is not medically indicated or will not improve the likelihood of conception due to multifactorial causes of infertility.

d. Surrogacy and any fees associated with it (maternity services are covered for Members acting as a surrogate mother).

e. Medical and surgical procedures that are experimental or investigational, unless such denial is overturned by an External Appeal Agent.

f. Services requested which are not medically appropriate.

g. Services not specifically listed as covered in this benefit.

h. Services rendered by non-participating providers, unless authorized by Anthem's Medical Management Program.

i. Elective oocyte and/or sperm cryopreservation.

Claims and Appeals

Please see the *Medical Claims and Appeals* section of this SPD for instructions and further information regarding claims and appeals.

PRESCRIPTION DRUG BENEFITS

(Administered by Express Scripts Inc. – Group K4DA)

The Prescription Benefit provided by the Plan is self-insured and administered by Express Scripts, Inc. (ESI). The Plan provides coverage for prescription drugs purchased at participating retail pharmacies or through the mail-order pharmacy, which is mandatory for maintenance medications. Coverage depends on which option you use. You will receive an ESI identification card when you first become eligible for Plan coverage.

To help you understand the Prescription Benefit, the following explanations may be useful:

- *Copayment* – The amount you (and not the Plan) pay for a prescription drug.
- *Formulary or Preferred Brand* – A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Certain drugs are excluded from the Formulary.
- *Generic* – A drug that has the same active ingredients in the same dosage form and strength as its brand- name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. See *Generic Drug Rules* below for more information.
- *Maintenance medication* – Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide members with lower costs and more convenience. Please see information below about home delivery.
- *Non preferred brand drugs, or non-formulary drugs* – Medications that the Express Scripts team of physicians and pharmacists have not approved for the Express Scripts formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.
- *Specialty drug* – A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

How to Obtain Your Prescription Drugs

Express Scripts has established a network of pharmacies through which you may fill prescriptions. If you use one of ESI's Network Pharmacies, your out-of-pocket costs may be lower than if you use a Non-Network Pharmacy.

The ESI network consists of over 70,000 pharmacies nationally. To find a Network Pharmacy, visit express-scripts.com and use the Pharmacy Locator. You can also download the Express

Scripts mobile app or contact ESI customer service at **(800) 451-6245**, Monday – Friday 9 am to 5 pm.

For service, simply present your ID card and a valid prescription at any Network Pharmacy. The Network Pharmacy will dispense a prescription in a quantity not to exceed a 30-day supply and collect the applicable Copayment. You will be asked to sign a signature log to verify that you picked up the medication. While a pharmacy can usually check eligibility online through ESI, if you purchase a prescription at a Network Pharmacy without your ID card, you might need to pay for the prescription and submit a claim to ESI for reimbursement.

If you go to a Non-Network pharmacy (or if you go to an Network Pharmacy but do not use your coverage at the time of purchase), you must pay the full retail cost for the prescription. The amount you pay does not count against the Plan's Out-of-Network Out-of-Pocket Maximum or Deductible. You must then file a claim for reimbursement with Express Scripts no later than 18 months from date of purchase. See more information in the *Claims for Prescription Drug Benefits* section below. Claim forms are available from ESI.

Please note any difference in the cost of the prescription at a Non-Network pharmacy and the amount allowed by the Plan is your responsibility. For Non-Network claims, the Plan reimburses the allowed amount that would have been paid to a Network pharmacy; you are responsible for any difference between the allowed amount and the retail cost charged by the pharmacy, plus the applicable Copayment. The Plan cannot under any circumstance provide benefits in excess of the Network allowed amount.

Because the difference between the Network allowed amount and what your pharmacy charged can be significant, it is important to use Network pharmacies and to ensure that you have proof of coverage when you use a Network pharmacy.

ESI Mobile App

1. View your ID card right on your device
2. View all of your medications as well as view lower-cost prescription options
3. Locate a pharmacy
4. Order and track your medication delivered to your home
5. Set reminders to take or reorder your prescription

With the ESI mobile app, you can view up-to-the-minute order status and use a handy "medicine cabinet" to keep track of prescriptions.

Express Scripts (ESI)
Customer Service: (800) 451-6245
TDD for hearing impaired: (800) 972-4348
Pharmacist only: (800) 235-4357

Website: www.express-scripts.com		
	Employee/Spouse or Registered Domestic Partner/Dependent(s)	
RETAIL PHARMACY & HOME DELIVERY	**IN-NETWORK *Copayments apply toward Out-of-Pocket Maximum**	**OUT-OF-NETWORK**
RETAIL (up to 30-day supply)		Member reimbursed at Network allowed amount minus applicable Copayment
Generic	$5 Copayment	
Formulary (Preferred Brand)	$15 Copayment	
Non-Formulary (Non-Preferred Brand)	$30 Copayment	
Diabetic Supplies and Antidiabetic Medications	$15 Copayment	
HOME DELIVERY (31 to 90-day supply) *less than 31-day supply, retail Copayments apply		**Not covered**
Generic	$10 Copayment	
Formulary (Preferred Brand)	$30 Copayment	
Non-Formulary (Non-Preferred Brand)	$60 Copayment	
Diabetic Supplies and Antidiabetic Medications	$15 Copayment	
Submit pharmacy claims to: Express Scripts, Inc. P.O. Box 66583 St. Louis, MO 66583		

Home Delivery

The retail pharmacy is the most convenient option when a medication is needed immediately. The home delivery program is designed to be more convenient and less expensive for you to obtain drugs that you use on a long-term basis, such as those that are prescribed for high blood pressure, diabetes, asthma, or similar long-term conditions. Maintenance drugs are used for these types of long-term conditions. Using the home delivery program saves you money because you receive a greater supply of drugs for less in Copayments.

You can order home delivery by mail, online, the ESI App, or phone. Visit express-scripts.com for more information. If by mail, fill out all of the information on the mail order envelope (which you may request from ESI), including any allergies and relevant medical conditions. Enclose your Copayment for each prescription (see the Copayment chart above) and be sure to write your return address on the envelope, including your apartment number. Mail order forms are available at www.express-scripts.com.

Refills at Retail Pharmacy or Online

- Prescriptions filled at a retail pharmacy are available for refill when you have 25% supply left.
- Mail order prescriptions are available for refill when you have a 30-day supply left. You can refill your mail order prescriptions anytime on the internet at www.express-scripts.com. You can also refill your prescriptions over the telephone by calling (866) 439-3658 and following the instructions. To check the status of a mail order prescription, call ESI or check the website.

Use of the Formulary

ESI has negotiated preferred pricing on certain drugs, included on a list called a Formulary. As a result of this preferred pricing (often on drugs by different manufacturers for the same medical condition), lower Copayments can be offered on formulary drugs. Use of these drugs saves both you and the Plan money and their use is encouraged.

The Formulary and conditions of drug coverage under the Plan, as well as exclusions, is subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call ESI Member Services at (866) 439-3658. A pharmacist can also check whether a medication is on the Formulary or covered at any time. Clinically effective alternatives are available for all excluded Formulary products.

Your prescriber may request an exception to the Formulary exclusion. ESI contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the Formulary exclusion. If the exception is denied, the patient may appeal the determination.

Covered Prescription Drugs

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and brand-name drugs.

Some drugs are not covered, or excluded, meaning there are no alternatives to try or exceptions to coverage. To check whether a medication is excluded, go to express-scripts.com or call ESI Member Services at (866) 439-3658.

- The maximum you can spend on infertility medications every year is $10,000 per calendar year (January 1 to December 31).

Coverage is provided only for those drugs and medicines that are:

- Approved by the US Food and Drug Administration (FDA) as requiring a prescription;
- FDA approved for the condition, dose, route, duration and frequency for which they are prescribed;
- Prescribed by a physician or other health care provider authorized by law to prescribe them; and
- Not otherwise excluded.

Generic Drug Rules

If you request a brand name drug when a generic drug is available, the Plan will only cover the cost of the generic drug; you will need to pay the difference in cost between the brand and generic drug plus the generic Copayment.

Coverage for Over-the-Counter At-Home COVID-19 Diagnostic Tests

Until further notice, the Plan will cover FDA-authorized over the counter ("OTC") at-home test kits to diagnose COVID-19 ("OTC tests"), at no cost to you as follows. This coverage is available for OTC tests purchased from a pharmacy or retailer on and after January 15, 2022. Any non-retailer or private party sale of OTC tests (in person or on a third-party website) will not be covered by this benefit.

The Plan will cover up to eight (8) OTC tests per covered individual per 30-day period. Note that if you purchase a kit with more than one test in the kit, the 8-test limit applies to the number of tests, not the number of kits. For example, if you purchase a kit with two (2) tests in the kit, the Plan will only pay for up to four (4) kits per covered individual per 30-day period.

Coverage will be available only when OTC tests are purchased for personal use, will not be resold or distributed, are not for employment purposes, and have not been and will not be reimbursed by another source. **For OTC tests purchased on or after January 28, 2022, the maximum reimbursement for each OTC test is $12.00 per test.**

You can obtain OTC tests directly at retail pharmacies in the Express Scripts network with no out-of-pocket costs by showing your Express Scripts ID card at the pharmacy counter. If you get your OTC tests from a retail pharmacy in the Express Scripts network, you will not need to pay for them or file for reimbursement.

OTC tests can also be obtained without any out-of-pocket costs through the Express Scripts website and sent directly to your home. Please visit https://www.express-scripts.com/covid-19/resource-center for more information.

The Plan will also cover OTC tests purchased at a pharmacy outside of the Express Scripts network or from a retailer. You will need to pay for the OTC tests, get an itemized receipt that indicates the type of tests, number of tests purchased, date purchased and paid amount, and submit a claim for reimbursement. Claims for reimbursement can be submitted electronically or they can be mailed to Express Scripts. Please visit https://www.express-scripts.com/covid-19/resource-center for instructions on how to submit a claim for reimbursement.

ACA-Preventive Medications and Supplies

The Affordable Care Act (ACA) makes certain preventive medications available to you at no cost. Preventive medications are covered 100% for generic prescription drugs, as well as certain brand name drugs if a generic is unavailable or medically inappropriate. A list of medications that are covered under this provision are listed below. *Coverage of any preventive medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care Provider*.

The list of covered medications is subject to change as ACA guidelines are updated or modified. For the most up-to-date information or more information about which preventative prescription drugs are covered at 100%, please contact ESI.

- Aspirin for primary prevention of cardiovascular disease and colorectal cancer in specific adult populations; and low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with Plan rules.
- FDA-approved contraceptive methods for women, including barrier methods, hormonal methods and implanted devices, as prescribed by a health care Provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care Provider.
- Folic Acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only with a prescription.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age and younger than five years whose primary water source is deficient in fluoride, in primary care practices. Over-the-counter supplements are covered only with a prescription.
- All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for adults 18 and older when prescribed by a health care Provider without prior authorization. Over-the-counter medications are covered only with a prescription.

- Bowel Preps in connection with a screening colonoscopy for adults between ages 45 and 75. Over-the-counter medications are covered only with a prescription.
- Risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and at a low risk for adverse medication effects.
- Low-to-moderate-dose statin medication for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater.
- HIV PrEP. Pre-exposure prophylaxis with effective antiretroviral therapy for individuals at high risk for HIV infection.
- ACA-required vaccines. These are generally covered under the Medical Benefits; see the *Medical Benefits* section of this SPD for details. In addition, you may contact ESI for information on benefits under the Prescription Benefit.

ESI Pharmacy Vaccination Program

You are eligible to receive a number of preventive vaccines covered through the ESI Pharmacy Vaccination Program. This program covers preventive vaccinations, including their administration, at In-Network retail pharmacies. Benefits paid are equal to the Allowed Charge for the vaccine, with no copay when received from an In-Network retail pharmacy. Eligible vaccines and participating pharmacies may change from time to time. *No benefits are available for vaccines received from non-participating pharmacies*.

Refer to the Express Scripts website for an updated list of eligible vaccines and In-Network retail pharmacies.

Provision of vaccinations is subject to the participating retail pharmacies' receipt of an adequate supply of vaccine. Not all participating retail pharmacies will stock all available vaccines. You should call the pharmacy to confirm availability or make an appointment before your visit.

Please note: each state establishes regulatory guidelines for vaccine administration. According to the regulatory requirements in New York State (NYS), licensed pharmacists certified as immunizers can administer pneumococcal, acute herpes zoster (shingles), hepatitis A, hepatitis B, human papillomavirus, measles, mumps, rubella, varicella, COVID-19, meningococcal, tetanus, diphtheria, or pertussis vaccinations to adults 18 years of age or older and influenza vaccines to patients two years of age or older.

Prior Authorization

You must obtain pre-authorization from Express Scripts in order to obtain coverage for certain prescription drugs. Your physician must call Express Scripts at (800) 753-2851 to initiate the pre-authorization process and to verify that the Plan covers the drug. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, you will pay the normal Copayment; if the medication is not covered but you would like to take it, you will pay the full retail price of the medication.

Medications requiring prior authorization may include, but are not limited to:

- brand-name medications with a generic equivalent
- medications with age limitations, and
- medications prescribed for a quantity exceeding normal limits.

Please be aware that the list of drugs requiring pre-authorization is subject to change. Contact ESI at (800) 753-2851 for up-to-date information.

Specialty Medications

To obtain any specialty medication, you must use ESI's specialty pharmacy, Accredo Health Group. To reach Accredo, call (800) 803-2523. Your physician can also call Accredo directly at (866) 759-1557 (just give your doctor your 12-digit ESI member identification number).

Please be aware that the drugs classified as specialty medications is subject to change. Contact ESI at (800) 753-2851 for up-to-date information.

Step Therapy

Step therapy is a process in which you may need to use one (1) or more type of Prescription Drugs before the Plan will cover another as Medically Necessary. This program requires a member to try a first-line therapy prior to receiving a second-line therapy. If the first-line drug therapy has been tried and is not effective, or the patient is intolerant (e.g., allergic), or has another medical reason they cannot take the first-line therapy, then the second-line therapy may be dispensed and covered under the drug benefit.

Drug Quantity Management

Certain drugs are a part of a drug quantity management (DQM) program. When you are prescribed these drugs, the DQM program reviews the amount or quantity prescribed for safety and effectiveness to determine the maximum quantity deemed safe.

EXCLUSIONS

Prescription drug benefits are not paid for:

- Prescriptions written by members for themselves.
- Drugs and/or medications:
    - Obtained after the date your coverage ends,
    - Filled for more than a 30-day supply at a retail pharmacy or a 90-day supply through mail order,
    - That are experimental and/or investigational, which means they are not approved by the FDA and are not legally available for distribution,
    - For which your cost is equal to or less than the Copayment,
    - Received while confined in a Hospital (however, these costs may be covered by the Plan's Medical Benefits through Anthem),

  - Dispensed for a purpose other than the treatments recommended by the FDA,
  - Prescribed as a result of an Injury or Illness covered by Workers' Compensation, or
  - Intended as nutritional or diet supplements, except where Medically Necessary for the treatment of eating disorders;

- Refills exceeding the number your physician prescribes;
- Refills more than one year after the date of the original prescription;
- Over-the-counter drugs or medications, except for aspirin and other prescribed preventive medications;
- Biological sera, blood or blood plasma (however, these may be covered by the Plan's Medical Benefits through Anthem);
- Fertility medications not expressly covered in the Plan's formulary;
- Growth hormones, except when Medically Necessary and pre-authorized;
- Alcohol wipes;
- Retin-A, except when Medically Necessary;
- Vitamins available without a doctor's prescription;
- Syringes for dispensing prescribed medication (these are covered by the Plan as medical supplies);
- Select Compounded Medications when there is no proven use or for drugs that have alternative commercially available products;
- Certain genetic therapies; and
- Excluded drugs: please contact ESI for the most up-to-date information on which drugs are not covered by the Plan.

PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR ELIGIBLE DEPENDENT(S) WHO ARE MEDICARE ELIGIBLE

Medicare covers prescription drug benefits under Part D Prescription Drug Plan. If you, as an active employee, and/or your eligible dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D Prescription Drug Plan. For active employees and their eligible dependent(s) who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that this Plan's prescription drug benefits are expected to pay out, on average, as much or more as the standard Medicare prescription drug benefits will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage as an eligible employee in order to avoid a late penalty under Medicare. When you lose coverage under this Plan, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15 to December 31 of each year). For more information about Creditable Coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from

the Plan once a year. You may request another copy of this Notice by emailing the Benefits Office at benefits@cirbenefitfunds.org or by calling (212) 356-8180.

CLAIMS FOR PRESCRIPTION DRUG BENEFITS

If you purchase a prescription at a Non-Participating Pharmacy, you will have to submit a claim along with the prescription drug receipt to ESI for reimbursement. You must submit the receipt(s) no later than 18 months from date of purchase to receive reimbursement. Claim forms may be obtained at www.express-scripts.com, on the Plan's website at www.cirseiu.org/benefits or by contacting Express Scripts customer service. Please see the *Claims and Appeals* section for more details on prescription drug claims.

You must complete a separate claim form for each pharmacy used and for each patient. You must enclose receipts including the following:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and dosage
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Mail all claims and receipts to: Express Scripts, Inc. Attn: STD ACCTS P.O. Box 66583 St. Louis, MO 63166-6583

Timetable for Notification by ESI on Your Initial Claim for Benefits

Depending on the type of claim, ESI will process it within the following timeframes:

- **Pre-Service Claim:** A Pre-Service Claim means any claim for a benefit under this Plan in which the Plan requires receipt of the benefit in whole or in part, on approval in advance of obtaining medical care. There are, for example, claims subject to precertification or pre-authorization. Please refer to the specific service to be provided to determine if pre-approval is required. Your Pre-Service Claim will have the following timeframe:

-Notification to claimant of benefit determination (for retail claims):	
-If approved, by automated telephone call (or letter if call is unsuccessful) within:	15 days
-If denied, by letter within:	15 days
-Extension for matters beyond the control of the Plan in writing within:	15 days

-Notification to claimant of benefit determination (for home delivery claims):
-If approved, by automated telephone call (or letter
if call is unsuccessful within: 5 days
-If denied, by letter within: 5 days
-Extension for matters beyond the control of the Plan in writing within: 15 days

If you have not provided sufficient information regarding your claim:

-You will receive notification by letter of failure to follow the Plan's
procedures for filing a Claim within: 15 days
-You must respond within: 45 days

- **Urgent/Expedited Claim:** A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. Your Urgent/Expedited Claim will have the following time frame:

-Notification to claimant of benefit determination within:
-If approved, by automated telephone call and letter within: 72 hours
-If denied, by live telephone call and letter within: 72 hours

If you have not provided sufficient information regarding your claim:

-You will receive notification, orally or in writing, of failure
to follow the Plan's procedures for filing a Claim within: 24 hours
-You must respond, orally or in writing, within: 48 hours
-Notification to claimant of benefit determination,
-If approved, by automated telephone call and letter within:
if telephone is unsuccessful within: 48 hours
-If denied, by letter within: 48 hours

- **Post-Service Claim:** A Post-Service Claim means any claim for a Plan benefit that is not a claim involving a Pre-Service Claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant. Your Post-Service Claim will have the following time-frame:

-If approved, by automated telephone call and then by letter
if call is unsuccessful within: 30 days
-If denied, by letter within: 30 days
-Extension due to matters beyond the control of the Plan: 15 days

If you have not provided sufficient information regarding your claim:

-Notification of failure to follow the Plan's procedures for filing a Claim within: 15 days
-You must respond within: 45 days

APPEALS

Internal Level 1 Appeals

If you are dissatisfied with the outcome of a claim for prescription benefits, you have the right to make an Internal Level 1 Appeal to ESI.

Your request for review must be made in writing within 180 days after you receive notice of denial to the appropriate department (see *How to File Your Appeal*, below).

Expedited Internal Level 1 Appeals

For a claim involving Urgent Care as defined above, ESI provides for Expedited Internal Level 1 Appeals (and may also be eligible for Expedited External Review, discussed below). Internal appeals must be made within 180 days to ESI at the applicable address found in *How to File Your Appeal* (below), or as follows:

- **Verbally**: Your doctor's office can call ESI at (800) 753-2851 and complete the process by phone.
- **Fax**: Your doctor's office can fax information to (877) 753-2851.

ESI will make a decision on your Internal Level 1 Appeal within the following timeframes:

- **Pre-Service Claim Appeal**

  -Notification to claimant of benefit determination:
  -If approved, by automated telephone call (or letter if call is unsuccessful) within: 15 days
  -If denied, by letter within: 15 days

- **Urgent/Expedited Claim Appeal**

  -Notification to claimant of benefit determination within:
  -If approved, by automated telephone call and letter within: 72 hours
  -If denied, by live telephone call and letter within: 72 hours

- **Post-Service Claim Appeal**

  -If approved, by automated telephone call and then by letter if call is unsuccessful within: 30 days
  -If denied, by letter within: 30 days

Internal Level 2 Appeals

If you are dissatisfied with the outcome from ESI you can file an Internal Level 2 Appeal (and a simultaneous request for Independent External Review, if eligible for Independent External Review) to ESI. Your request for a Level 2 Appeal must be made in writing to the appropriate department (see *How to File Your Appeal*, below) within ninety (90) days from receipt of notice of the denial of the Internal Level 1 Appeal. ESI will respond to your Internal Level 2 Appeal within the same time frames as Internal Level 1 Appeals, set forth above. There are no further levels of internal appeal although Independent External Review may be available in limited instances.

Expedited Level 2 Appeals

For a claim involving Urgent Care, such appeals must be made within 90 days to ESI at the applicable address found in *How to File Your Appeal* (below), or as follows:

- **Verbally**: Your doctor's office can call ESI at (800) 753-2851 and complete the process by phone.
- **Fax**: Your doctor's office can fax information to (877) 753-2851.

ESI may submit your Expedited Level 2 Appeal directly to Independent External Review, described below.

Independent External Review

If the outcome of a mandatory Internal Appeal is adverse to you, and it was based on medical judgment, pertained to a rescission of coverage, or a determination that care was experimental or investigational, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for Independent External Review to ESI within four (4) months of the notice of either an Internal Level 1 or Internal Level 2 Appeal decision. Submit the request to the applicable address found in *How to File Your Appeal* (below).

A request for an External Review must be in writing unless ESI determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for an Internal Appeal. However, you are encouraged to submit any additional information that you think is important for review.

If your claim involved Urgent Care, you may request an Expedited External Review at the same time as your Internal Level 1 review. If you do not, and the Internal Level 1 Appeal determination is adverse to you, you may request an Expedited External Review; if you request an Internal Level 2 Appeal for an Urgent Care claim, ESI may submit your appeal directly to Expedited External Review.

Requests for External Review may be submitted to the applicable address found in *How to File Your Appeal* (below), or as follows:

- **Verbally**: Your doctor's office can call ESI at (800) 753-2851 and complete the process by phone.

- **Fax**: Your doctor's office can fax information to (877) 753-2851.

Your decision to seek External Review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent External Review. However, the External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

How to File Your Appeal

To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests (addresses below).

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the denial
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

If ESI denied your claim (or your Internal Level 1 Appeal) on the basis of clinical guidelines and/or FDA-approved prescribing and safety information, direct your appeal to:

Express Scripts, Inc.
Attn: Clinical Appeals
P.O. Box 66588
St. Louis, MO 63166-6588

Fax: (877) 857-4070, Attn: Clinical Appeals Department
Phone: (800) 753-2851

If ESI denied your claim (or your Internal Level 1 Appeal) because the medication is excluded from the Plan Formulary or a similar reason, direct your appeal to:

Express Scripts, Inc.
Attn: Administrative Appeals
P.O. Box 66587
St. Louis, MO 63166-6587

Fax (877) 328-9660, Attn: Administrative Appeals Department
Phone: (800) 946-3979

DENTAL BENEFITS

(Insured By Guardian – Group #417733)

DENTAL EXPENSE COVERAGE

Guardian administers the dental plan which has two options from which you can choose for yourself and your eligible dependent(s). Managed DentalGuard (MDG) is a Dental Managed Organization plan which functions much like an HMO does for health care. The alternate plan is called DentalGuard Preferred (DGP) which is a Preferred Provider Organization which will allow you to use either a dentist who is participating in the plan or any dentist you choose, whether or not he or she is participating in the Guardian network.

You must choose one plan, either Managed DentalGuard or DentalGuard Preferred. If you do not choose a plan upon enrollment, you will be auto-enrolled in the MDG Plan if you live in the tri-state area and auto-enrolled in the DGP Plan if you live outside of the tri-state area.

Either plan will cover many of the dental expenses incurred by you and those of your dependent(s) who are covered for dental benefits under this plan. However, the most economical plan for you and your dependent(s) will be the Managed DentalGuard, while the DentalGuard Preferred plan will allow you greater choice of dentists. If you choose the DentalGuard Preferred plan, your costs will be less if you choose dentists who are participating in the network over those who are not.

Guardian decides: (a) the requirements for services to be paid; and (b) what benefits are to be paid by either plan. Guardian also interprets how the plan is to be administered. What Guardian covers and the terms of coverage are explained below.

Dependent(s) Covered Up To Age 26

Child(ren) will be covered up to the end of the calendar year they turn 26.

MANAGED DENTALGUARD (MDG)

The MDG plan is designed to provide quality dental care while controlling the cost of such care. To do this, this plan requires members to seek dental care from participating dentists that belong to the MDG network. Except for emergency dental services, in no event will Guardian pay for dental care provided to a member by a non-participating dentist.

The MDG network is made up of participating dentists in a member's geographic area. A "participating dentist" is a dentist that has an MDG participation agreement in force with Guardian.

When a member enrolls in this plan, he or she will get information about Guardian's current participating general dentists. Each member must select from this list of participating general dentists a primary care dentist (PCD) who will be responsible for coordinating all of the member's dental care. If a member does not select a dentist for themselves or eligible dependent(s) they will automatically be defaulted to the provider closest to their home address under the Managed DentalGuard Plan. **If a member's address is outside of the tri-state area they must select a**

PCD within the tri-state area or select the Dental Guard Preferred plan. Guardian cannot automatically default you to the provider closest to your home address.

If a member does not complete an enrollment card for dental within thirty days from their date of hire, they will not be able to enroll until the next Open Enrollment Period, and at that time, the member can select either MDG or DGP (effective either January 1 or July 1).

After enrollment, a member will receive an MDG ID card. A member must present this ID card when he or she goes to his or her PCD. All dental services covered by this plan must be coordinated by the PCD whom the member selects or is assigned to upon enrolling in this plan. What Guardian covers is based on all the terms of this plan. Read this plan carefully for specific benefit levels, exclusions, coverage limits and patient charges.

Choice of Dentists

A member may select any available participating general dentist within the tri-state area as his or her PCD. A request to change PCDs must be made to Guardian. Any such change will be effective the first day of the month following approval. Guardian may require up to 30 days to process and approve any such request. All fees and patient charges due to the member's current PCD must be paid in full prior to such transfer.

Guardian compensates participating general dentists through an advance payment agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD. In addition, Guardian may make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general dentist receives from Guardian. The dentists also receive compensation from plan members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown below.

Specialty Referrals

A member's PCD is responsible for providing all covered services. But certain services may be eligible for referral to a participating specialist. Guardian will pay for covered services for specialty care, less any applicable patient charges, when such specialty services are provided in accordance with the specialty referral process.

All specialty referral services must be:
A) Pre-authorized by Guardian; **and**
B) Coordinated by a member's PCD.

Any member who elects specialist care without prior referral by his or her PCD and approval by Guardian is responsible for all charges incurred.

Guardian compensates their participating specialists the difference between their contracted fee and the patient charge shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that participating specialists receive from Guardian.

Emergency Dental Services

Guardian provides for emergency dental services 24/7, to all members. A member should contact his or her assigned PCD who will make arrangements for such care.

During normal business hours: If a member is unable to reach his or her PCD in an emergency during normal business hours, he or she must call our Member Services Department for instructions at (888) 618-2016.

After normal business hours: If a member is unable to reach his or her PCD in an emergency after normal business hours, the member may seek emergency dental services from any dentist. Then, within 2 business days, the member should call Guardian to advise of the emergency claim.

The member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. Guardian will reimburse the member for the cost of the emergency dental services, less any patient charge which may apply.

Out-Of-Area Emergency Dental Services

If a member is more than 50 miles from his or her home and emergency dental services are required, he or she should seek care from a dentist. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating dentist. The statement must list all services provided. Guardian will reimburse the member within 30 days for any covered emergency dental services, up to a maximum of $50.00 per incident, after payment of any patient charge which may apply.

Covered Dental Services & Patient Charges

The services covered by this Plan are set out in the Guardian Class #1 Certificate. If a procedure is not listed, it is not covered. All services must be provided by the Member's Primary Care Dentist (PCD). A summary of services is described further on page 122, below.

The Member must pay the listed Patient Charge. Guardian covers the rest of the Participating Dentist's charge for the service. The benefits Guardian provides are subject to all the terms of this Plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

These Patient Charges are only valid for covered services rendered by Participating Dentists in the MDG network.

MDG Exclusions

Coverage is limited to covered services only. This MDG plan does not pay for, including, but not limited to, the following: any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law, or under any other non-dental insurance or benefit plan; dental services performed in a hospital or related hospital fees, or charges for the use of any facility, equipment, or supplies provided outside

of the participating dentist's office; any treatment or appliance: (a) which, in the opinion of the participating dentist, Guardian's dental director, or his or her authorized agent will not achieve a satisfactory result; or (b) which is solely for cosmetic purposes; dental services received from any dentist other than the selected and assigned PCD, unless expressly authorized in writing by the plan (this will not apply to emergency dental services); consultations for non-covered services; and any procedure not listed as a covered service.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents control final terms of coverage.

For additional information, call Guardian Member Services at (800) 541-7846. For certificate(s) of coverage, please contact the Benefits Office at (212) 356-8180.

DENTALGUARD PREFERRED (DGP)

DGP is the alternate plan to Managed DentalGuard. DGP is a Preferred Provider Organization (PPO) which allows the member and eligible dependent(s) greater freedom in choice of dentists but will also incur greater costs for the services rendered. The DGP plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the DGP plan encourages a covered person to seek dental care from dentists and dental care facilities that are under contract with Guardian's PPO.

The DGP plan usually pays a higher payment for benefits for covered treatment furnished by a preferred provider. Conversely, it usually pays less for covered treatment furnished by a non-preferred provider.

DGP is made up of preferred providers in a covered person's geographic area. Use of DGP is voluntary. A covered person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

When an employee enrolls in this plan, he or she and his or her dependent(s) receive a dental plan ID card and information about current preferred providers.

A covered person must present his or her ID card when he or she uses a preferred provider. Most preferred providers prepare necessary claim forms for the covered person and submit the forms to Guardian. Guardian sends the covered person an explanation of DGP's benefit payments, but any benefit payable by Guardian is sent directly to the preferred provider.

What Guardian pays is based on all of the terms of DGP. Please read this plan carefully for specific benefit levels, Deductibles, payment rates and payment limits.

A covered person may call Guardian at the number shown on his or her ID card with any questions.

COVERED CHARGES

If a covered person uses the services of a preferred provider, covered charges are the charges listed in the fee schedule. The preferred provider has agreed to accept as payment in full for the dental services listed in this plan's List of Covered Dental Services.

If a covered person uses the services of a non-preferred provider, covered charges are reasonable and customary charges for the dental services listed in DGP's List of Covered Dental Services (see chart on page 118).

To be covered by DGP, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

Guardian may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By "reasonable," Guardian means the charge is the dentist's usual charge for the service furnished. By "customary," Guardian means the charge made for the given dental condition isn't more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under DGP, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planning; if the scaling and root planning is performed one or two weeks prior to the osseous surgery, Guardian may only pay benefits for the osseous surgery.

Guardian only pays benefits for covered charges incurred by a covered person while he or she is insured by DGP. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, Guardian will only pay benefits for services which are completed within 31 days of the date his or her coverage under DGP ends.

LIST OF COVERED DENTAL SERVICES UNDER DENTALGUARD PREFERRED		
Group I Services (Preventive, Non-Orthodontic Services)	**Preferred Provider**	**Non-Preferred Provider**
Annual Deductible	None	None
Includes prophylaxis and fluoride treatments, office visits, examinations and evaluations, X-rays and dental sealant treatments; limitations apply	100%	100% of Usual and Customary Rate (UCR)
Group II Services (Basic, Non-Orthodontic Services)	**Preferred Provider**	**Non-Preferred Provider**

Annual Deductible	None	$25 for each covered person
Includes diagnostic, restorative, crown and prosthodontic restorative, endodontic, periodontal, periodontal surgery, non-surgical extractions, surgical extractions and other surgical services; limitations apply	80%	80% UCR
Group III Services (Major Services)	**Preferred Provider**	**Non-Preferred Provider**
Annual Deductible	None	$25 for each covered person
Includes major restorative services and prosthodontic services	50%	50%
Benefit Cycle Payment Limit for Non-Orthodontic Services	Up to $2,000	Up to $1,000
Orthodontic Services	Adult and Child Orthodontics 50% to lifetime maximum of $1,500	Adult and Child Orthodontics 50% to lifetime maximum of $1,500
Note: A covered person may be eligible for a rollover of a portion of his/her unused Benefit Cycle Payment Limit for Non-Orthodontic Services.		

A summary comparison chart is provided below at page 122.

Maximum Rollover Account for DGP Members Only:

With the Maximum Rollover Account (MRA), Guardian will rollover $350 for services rendered by a DentalGuard Preferred provider or $250 for an out-of-network provider into an MRA for every year that Guardian dental payouts are under $500 per insured individual.

If you continue to have less than $500 worth of annual claims, Guardian will rollover the $350 or $250 up to $1000 in your account. The MRA can be used in future years towards non-Orthodontic Services.

To qualify, a member must submit a claim and not exceed $500 threshold during the Benefit Cycle. The employee and each insured dependent(s) maintain separate MRAs based on their own claim activity. Guardian will only rollover up to a cumulative maximum amount of $1000 into your MRA.

Type of Provider	Max Claims Paid by Guardian	Amount Rollover to the Next Benefit Cycle	Max Amount Qualified for Rollover	Annual Limit Paid By Guardian	Max Amount Allowed in MRA

DentalGuard Preferred Provider	$500	$350	$1000	$2000	$1000
Out-of-Network Provider	$500	$250	$1000	$1000	$1000

- An employee joining the plan as a new hire with 3 months or less remaining in the Benefit Cycle: the MRA accumulation will begin as of the first full Benefit Cycle. (Example: For an Employee joining in May of 2023, claim activity between July 1, 2023 and June 30, 2024 will be used and applied to MRAs for use in the Benefit Cycle between July 1, 2024 and June 30, 2025).

- If your claims are more than $500 for the Benefit Cycle, Guardian will not rollover any funds.

Out-of-Pocket Charges

Guardian will be paid for services only up to the maximum fee level established with our contracted network dentists. Any amount that is charged over the fee schedule is the responsibility of the patient.

How Much Do I Owe Before the Services are Rendered?

Pre-treatment Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300.

- Have your dentist fax your treatment plan to Guardian, note that it is a pre-treatment review and we will let your dentist know what benefits would be payable.

Special Limitation

- Teeth lost or missing before a covered person becomes insured by DGP. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he or she became insured by DGP. For the first 12 months that a covered person is insured by DGP, Guardian will not pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by DGP.

- If DGP replaces a Prior Plan, DGP will not pay for dental prothesis that replace teeth extracted while the covered person was insured by the Prior Plan and the Prior Plan paid for the extraction(s).

Third Party Injuries

If a covered person is injured because of a third party’s wrongful act or negligence:

- Guardian will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by DGP, if the covered person: (a) agrees in writing to Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice Guardian's subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist Guardian in any recovery;
- Guardian will be subrogated only to the extent of benefits paid by DGP because of that injury; and
- Guardian will be subrogated only when the amounts (or portion) received by the covered person through a third-party settlement or satisfied judgment is specifically identified as amounts paid as benefits under DGP.

DentalGuard Preferred General Limitations and Exclusions

This DGP policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles may apply for some options. DGP does not pay for: oral hygiene services (except as covered under preventive services), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. DGP limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontics, and prosthodontic services.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents control final terms of coverage.

For additional information, call Guardian Member Services at (800) 541-7846.

SUMMARY OF DENTAL BENEFITS FOR MANAGED DENTALGUARD AND DENTALGUARD PREFERRED PLANS

This is only a partial list of dental services and coverage is subject to change; your Guardian Dental Certificate of Coverage will show what is covered and excluded and you may visit GuardianLife.com for up-to-date coverage information.

Dental Plan	**Managed DentalGuard**	**Dental Guard Preferred with PPO Providers**	
	In-Network *Only*	In-Network	Out of Network
	Amount you pay You must pay a copay for each covered procedure	You must pay Coinsurance for each covered procedure that the Plan pays at less than 100%	Plan pays a percentage of the Reasonable and Customary amount; you must pay for any additional amount charged by the provider
Deductible	No Deductible	$0	$25 3 per family Deductible waived for preventive services
Annual Maximum Benefit	Not applicable	$2,000 $1,000 Combined In-Network and Out-of-Network maximum of $1,000 with an additional $1,000 of benefit In-Network	
Maximum Rollover Rollover Threshold Rollover Amount Rollover In-network Amount Rollover Account Limit	Not applicable	Yes $500 $250 $350 $1,000	
Lifetime Orthodontia Maximum	Not applicable	$1,500	
Office Visit Copay	$0	$0	
Dependent Age Limit	29	29	
Procedures			
Preventive Care			
Cleaning (prophylaxis)	$0 (2 visits/12 months)[1]	100% (every 6 months)	100% (every 6 months)
Fluoride Treatments	$0 (under 18)	100% (under 14)	100% (under 14)
Oral Exams	$0	100%	100%
Sealants (per tooth)	$0	100%	100%
X-Rays	$0	100%	100%
Basic Care			
Anesthesia[2]	Not Covered	80%	80%
Fillings[3]	$0	80%	80%

Perio Surgery Periodontal Maintenance Repair and Maintenance of Crown, Bridges and Dentures Root Canal Scaling and Root Planning (per quadrant) Simple Extractions Surgical Extractions	$380 $0 (once every 3 to 6 months) $88-120 $0-$270 $0 $0 $0-$160	80% 80% (once every 6 months) 80% 80% 80% 80% 80%	80% 80% (once every 6 months) 80% 80% 80% 80% 80%
Major Care Bridges and Dentures Inlays, Onlays, Veneers[4] Single Crowns	 $362-$400 $256-$304 $316	 50% 50% 50%	 50% 50% 50%
Orthodontia (adults & children)	$2,425[5]	50% with lifetime maximum of $1,500	50% with lifetime maximum of $1,500

[1]For MDG members: the total number of cleanings and periodontal maintenance procedures are combined in a 12-month period.
[2]For PPO members: General Anesthesia – restrictions apply.
[3]For PPO members: Fillings – restrictions may apply to composite fillings.
[4]For PPO members: Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material.
[5]Limited to one course of treatment per member per lifetime, pre-authorization required. Must be performed by participating provider.

DENTAL CLAIMS AND APPEALS

The processes for dental claims, grievances and appeals are further described in the certificates of insurance and/or benefits booklet for the Managed DentalGuard ("MDG") and DentalGuard Preferred ("DGP") coverage options. In the event of a conflict between terms in this SPD and the Guardian certificate of coverage or benefits book, the terms certificate of coverage or benefits book will control. For a copy of the Guardian certificate of coverage, please contact the Benefits Office at (212) 356-8180.

MDG Dental Claims, Grievances, and Appeals

If you receive services from a dentist of the Guardian Managed Dental Guard (MDG) network, you do not have to submit a claim form. If you are referred to a specialist, you must submit a claim to Guardian yourself, although most specialists prepare necessary claim forms for the covered person and submit the forms to Guardian.

If a request for access to a specialist is denied, or if coverage is denied because it is determined that the service or procedure is not covered by the Plan, the member or the provider may request re-evaluation under MDG's grievance process. If you are not satisfied with the grievance process, you may appeal, and in some instances, you may also be able to request external review.

The MDG grievance procedure applies to any issue **not** relating utilization review. Issues relating to utilization review are determinations relating to Medical Necessity or experimental or investigational claims. Rather, the MDG grievance procedure applies to contractual benefit denials or issues or concerns regarding Guardian's administrative policies or access to Dentists. Adverse benefit determinations not covered by the Grievance Procedures, including utilization review determinations, are covered by the Internal Appeals procedures, below.

Filing a Grievance. Members can contact Guardian by phone at (888) 618-2016 or in writing to file a Grievance. The Member must use Guardian's Grievance form for written Grievances. The Member may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination and Guardian may require that the Member sign a written acknowledgment of the Member's oral Grievance, prepared by Guardian. The Member or Member's designee has up to 180 calendar days from when Member received the decision that the Member is asking Guardian to review to file the Grievance.

When Guardian receives the Member's Grievance, Guardian will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Member's Grievance, and indicate what additional information, if any, must be provided.

Guardian keeps all requests and discussions confidential and take no discriminatory action because of a Member's issue. Guardian has a process for both standard and expedited Grievances, depending on the nature of Member's inquiry.

To initiate a grievance, the member or provider may contact Guardian at:

Guardian Member Services

P.O. Box 4391
Woodland Hills, CA 91367
(888) 618-2016

Grievance Determination. Qualified personnel will review the Member's Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. Guardian will decide the Grievance and notify the Member in writing within the following timeframes:

Expedited/Urgent Grievance:	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receiving the Grievance.
Pre-Service Grievances: (a request for a service or treatment that has not yet been provided)	In writing, within 30 calendar days of receipt of Member's Grievance.
All Other Grievances: (that are not in relation to a claim or request for a service)	In writing, within 30 calendar days of receipt of Member's Grievance.

Grievance Appeals. If you are not satisfied with the resolution of your Grievance, the Member or Member's designee may file an Appeal by phone at (888) 618-2016 or in writing at the address shown above for Grievance filings. The Member has up to 60 business days from receipt of the Grievance determination to file an Appeal.

When Guardian receives the appeal, Guardian will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling the Member's Appeal and indicate what additional information, if any, must be provided. One or more qualified personnel at a higher level than the person that made the first Grievance determination will review it. Guardian will decide the Appeal and notify the Member in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days after receiving all necessary information or 72 hours after receiving the Member's Appeal.
Pre-Service Grievances:	15 calendar days of receipt of Member's Appeal.
Post-Service Grievances: (a claim for a service or a treatment that has already been provided)	30 calendar days of receipt of Member's Appeal.
All Other Grievances:	30 business days of receipt of all necessary information to make a determination.

Assistance. If a Member remains dissatisfied with Guardian's Appeal determination, or at any other time Member is dissatisfied, the Member may call the New York State Department of Financial Services at (800) 342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If a Member needs assistance filing a Grievance or Appeal, the Member may also contact the independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Telephone: (888) 614-5400
Email: cha@cssny.org
www.communityhealthadvocates.org

Utilization Review and Internal Appeals

Utilization Review. Guardian reviews dental services to determine whether the services are or were Medically Necessary or experimental or investigation ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If a Member has any questions about the Utilization Review process, the Member may call (800) 618-2016 or the number on Member's ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Dentists; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Dentist who typically manages the Member's dental condition or disease or provides the dental care service under review. Guardian does not compensate or provide financial incentives to their employees for determining that services are not Medically Necessary. Guardian has developed guidelines and protocols to assist in this process. Specific guidelines and protocols are available for review upon request. Refer to your Guardian Booklet for additional information.

Reconsideration of Utilization Review Determinations. If Guardian did not attempt to consult with the Member's Dentist before making an adverse determination based on a utilization review, including a determination that a service was not Medically Necessary, or was experimental or investigational, the Member's Dentist may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If

the adverse determination is upheld, a notice of adverse determination will be given to the Member and the Member's Dentist, by telephone and in writing.

Internal Appeals. The Member has up to 180 days after the Member receives notice of the adverse determination to file an Appeal. The Member, Member's designee, and in retrospective review cases, the Member's Dentist, may request an internal Appeal of an adverse determination, either by phone or in writing. A clinical peer reviewer who is a Dentist or a Health Care Professional in the same or similar specialty as the Dentist who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

Preauthorization Appeal. If the Member's Appeal relates to a Preauthorization request, Guardian will decide the Appeal within 30 calendar days of receipt.

Retrospective Appeal. If the Member's Appeal relates to a retrospective claim, Guardian will decide the Appeal within 60 calendar days of receipt.

Expedited Appeal. An appeal of a review of continued or extended dental care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Dentist requests an immediate review, or any other urgent matter will be handled on an expedited basis. For an expedited Appeal, the Member's Dentist will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If the Member is not satisfied with the resolution of the expedited Appeal, the Member may file a standard internal appeal or, in some cases, an external appeal., as explained below in this section under *External Appeals*.

Guardian's failure to render a determination of the Member's Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Appeal Assistance. If a Member needs Assistance filing an Appeal, the Member may contact the independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Telephone: (888) 614-5400,
Email: cha@cssny.cssyy.org
www.communityhealthadvocates.org

Right to sue. If you are still unsatisfied after a grievance appeal has been decided, you have the right to bring a civil action in court.

External Appeals. In cases where Guardian has determined that the service is not Medically Necessary, or is experimental or investigative, a Member may have the right under New York law to request an External Appeal. External Appeals are discussed below.

DGP Dental Claims and Appeals

If you have selected Dental Guard Preferred (DGP), a covered person must present his or her ID card when he or she uses a preferred provider. Most preferred providers prepare necessary claim forms for the covered person, and submit the forms to Guardian. Guardian sends the covered person an explanation of DGP's benefit payments, but any benefit payable by Guardian is sent directly to the preferred provider. Otherwise, you must submit a claim form to Guardian within one (1) year from the date of service. You must also submit a claim form to Guardian within one (1) year of the date of service for any services performed by a non-preferred provider.

Mail your claim forms for DGP services to:

Guardian
Attention: Appeals Department
PO Box 981572
El Paso, TX 79998-1572
Fax: (509) 468-4590
Phone: (800) 541-7846

Your right to make a claim for any dental benefits provided by DGP is governed as follows:

Notice

You must send DGP written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include your name and plan number. If the claim is being made for one of your covered dependent(s), his or her name should also be noted.

Proof of Service

DGP will furnish you with forms for filing proof of services rendered within 15 days of receipt of the notice. But if DGP doesn't furnish the forms on time, DGP will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send DGP written proof within 90 days of the loss.

Late Notice of Proof

DGP will not void or reduce your claim if you cannot send DGP notice and proof of service rendered within the required time. But you must send DGP notice and proof as soon as reasonably possible.

Payment of Benefits

DGP will pay all dental benefits to which you are entitled as soon as DGP receives written proof of services rendered. DGP pays all dental benefits to you, if you are living. If you are not living, DGP has the right to pay all dental benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your child(ren); (e) your brothers and sisters; and (f) any unpaid provider of health care services. When you file proof of loss, you may direct DGP, in writing, to pay dental benefits to the recognized provider of health care who provided the covered service for which benefits became payable. DGP may honor such direction at its option. But DGP cannot tell you that a particular provider must provide such care. And you may not assign your right to take legal action under DGP to such provider.

Limitations of Actions

You cannot bring a legal action against DGP until 60 days from the date you file proof of loss. And you cannot bring legal action against DGP after three years from the date you file proof of loss.

Proof of Claim

So that DGP may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to DGP. This information may, at DGP's discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If DGP does not receive the necessary information, DGP may pay no benefits, or minimum benefits. However, if DGP receives the necessary information within 15 months of the date of service, DGP will redetermine the covered person's benefits based on the new information. Failure to furnish such proof within such time will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

Post-Service Claims

DGP will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, DGP will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim. The time period for completing a benefit determination may be extended by up to 15 days if DGP determines that an extension is necessary due to matters beyond the control of DGP, and so notifies the claimant before the end of the initial 30-day period. If DGP extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

DENTALGUARD PREFERRED APPEALS

If your claim is denied, Guardian will provide a notice to you that will set forth:

- The specific reason for the adverse benefit determination.

- A reference to the specific plan provision(s) on which the determination was based.
- A description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed.
- A description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA following a final adverse benefit determination.
- Identification and a description of any internal rule, guideline or protocol relied upon in making the determination, or a statement that a copy of such information will be provided to you upon request.
- In the case of a determination based on medical necessity or experimental or investigational treatment, the notice will either include an explanation of the scientific or clinical basis for the determination or explain how you may obtain it free of charge upon request.
- If your claim was urgent, a description of the expedited review process.

Appeals for dental benefits should be directed to Guardian in writing at the address below. Your request for review must be made in writing within 180 days after you receive notice of denial. You should include all relevant materials and information, including materials and information from your provider.

If your appeal involves an urgent care claim, you may either call Guardian Member Services at (888) 600-1600 or address your appeal in writing to:

Guardian
Attention: Appeals Department
PO Box 981572
El Paso, TX 79998-1572
Fax: (509) 468-4590
Phone: (800) 541-7846

External Appeals. In cases where Guardian has determined that the service is not Medically Necessary, or is experimental or investigative, a Member may have the right under New York law to request an External Appeal. External Appeals are discussed below.

EXTERNAL APPEALS

Member's Right to an External Appeal. In some cases involving utilization review, the Member has a right under New York law to an external appeal of a denial of coverage. If Guardian has denied coverage on the basis that a service does not meet Guardian's requirements for Medical Necessity (including appropriateness, dental care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), the Member or Member's representative may appeal that decision to an External Appeal Agent, an independent third party certified by New York State to conduct these appeals.

In order for the Member to be eligible for an external appeal, the Member must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; **and**
- In general, the Member must have received a final adverse determination through Guardian's Internal Appeal process. But, the Member can file an external appeal even though the Member has not received a final adverse determination through Guardian's Internal Appeal process if:
    - Guardian agrees in writing to waive the Internal Appeal;
    - The Member files an external Appeal at the same time as the Member applies for an expedited Internal Appeal; **or**
    - Guardian fails to adhere to Utilization Review claim processing requirements (other than a minor violation this is not likely to cause prejudice or harm to the Member, and Guardian demonstrates that the violation was for good cause or due to matters beyond Guardian's control and occurred during an ongoing, good faith exchange of information between Guardian and the Member).

Additionally**,** if Guardian has denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), the Member's attending Dentist must certify that the Member's condition or disease is one of which:

1. Standard dental services are ineffective or medically inappropriate;
2. There does not exist a more beneficial standard service or procedure covered by Guardian; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, the Member's attending Dentist must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available dental and scientific evidence indicate is likely to be more beneficial to the Member than any standard Covered Service (only certain documents will be considered in support of this recommendation; the Member's attending Dentist should contact New York State for current information as to what documents will be considered or acceptable);
2. A clinical trial for which the Member is eligible (only certain clinical trials can be considered); **or**
3. A rare disease treatment for which the Member attending Dentist certifies that there is no standard treatment that is likely to be more clinically beneficial to the Member than the requested service, the requested service is likely to benefit the Member in the treatment of the Member's rare disease, and such benefit outweighs the risk of the service. In addition, the Member's attending Dentist must certify that the Member's condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, the Member's attending Dentist must be a licensed, board-certified or board eligible Dentist qualified to practice in the area appropriate to treat the Member's condition or disease. In addition, for a rare disease treatment, the attending Dentist may not be the Member's treating Dentist.

External Appeal Process

It is the Member's responsibility to start the external appeal process. The Member may start the external appeal process by filing a completed application with the New York State Department of Financial Services. The Member may appoint a representative to assist with the application; however, the Department of Financial Services may request written confirmation.

Under New York State law, the Member's completed request for external appeal must be filed within four (4) months of either the date upon which the Member received a final adverse determination, or the date upon which the Member received a written waiver of any Internal Appeal, or Guardian's failure to adhere to claim processing requirements. Guardian has no authority to extend this deadline.

Guardian will provide an external appeal application with the final adverse determination or Guardian's written waiver of an Internal Appeal. The Member may also request an external appeal application from the New York State Department of Financial Services at (800) 400-8882. The completed application must be submitted to the Department of Financial Services at the address indicated on the application. If the Member meets the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The Member may submit additional documentation with the external appeal request. If the External Appeal Agent determines that the new information represents a material change from the information on which Guardian based its denial, the External Appeal Agent will share this information with Guardian in order for Guardian to exercise its right to reconsider its decision. If Guardian chooses to reconsider, Guardian will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited external appeal (described below), Guardian does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Member's completed application. The External Appeal Agent may request additional information from the Member, the Member's Dentist or Guardian. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Member in writing of its decision within two (2) business days.

If the Member's attending Dentist certifies that a delay in providing the service poses an imminent or serious threat to the Member's health; or if the Member's attending Dentist certifies that the standard external appeal time frame would seriously jeopardize the Member's life, health or ability to regain maximum function; or if the Member received emergency services and has not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, the Member may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of the Member's completed application. Immediately after reaching a decision, the External Appeal Agent must notify the

Member and Guardian by telephone or facsimile of that decision. The External Appeal Agent must also notify the Member in writing of its decision.

If the External Appeal Agent overturns Guardian's decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, Guardian will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigation treatment that is part of a clinical trial, Guardian will only cover the cost of services required to provide treatment to the Member according to the design of the trial. Guardian will not be responsible for the costs of investigational drugs or devices, the costs of non-dental care services, the costs of managing the research, or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both the Member and Guardian. The External Appeal Agent's decision is admissible in any court proceeding.

Guardian will charge the Member a fee of up to $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. Guardian will waive the fee if Guardian determines that paying the fee would be a hardship to you. If the External Appeal agent overturns the denial of overage, the fee will be refunded to the Member.

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00417733-HC
This section is a short summary of the dental benefits this plan provides. These dental benefits, including any exclusions and limitations, are fully outlined in the Guardian Dental Certificates of Coverage, which should be read along with this SPD for a complete description of your dental benefits. Please contact the Benefits Office for more details. This Guardian plan provides the following health insurance benefits: Dental Expense Insurance (defined as Dental Insurance by the New York State Insurance Department). This Guardian plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

SUPPLEMENTAL OUTPATIENT MENTAL HEALTH BENEFIT

(Self-Insured)

The Plan provides a self-insured Supplemental Outpatient Mental Health benefit. As of January 1, 2023, this benefit is available to participants employed by Children's National Hospital (CNH).*

This benefit supplements the outpatient mental health benefits provided by the Plan under Anthem (or the major medical coverage provided by CNH or other participating hospitals approved by the Trustees) by reimbursing up to $5,000 per Benefit Cycle per Employee and eligible dependent (including eligible spouses and domestic partners).

To be eligible for reimbursement, these services must be for eligible expenses, as defined below, rendered on an outpatient basis. The services must be covered by the medical coverage provided by this Plan through Anthem or, in the case of participants employed by CNH or other participating hospitals, the services must be covered by that participating hospital's medical coverage. If coverage for the service is denied by Anthem (or, as applicable, by the participating hospital's medical coverage), the expenses will not be reimbursable under this supplemental benefit. To the extent that telehealth mental health benefits are covered by the Plan (or the participating hospital's coverage), they are reimbursable under this benefit.

You must be enrolled in this Plan's coverage (or the participating hospital's coverage) and on your participating employer's payroll at the time that expenses are incurred. Outpatient mental health benefits will be reimbursed at 100% of your out-of-pocket expenses, including Copayments, Coinsurance, and/or Deductible charges, not to exceed $200 per office visit. In no instance will the Plan reimburse you more than what you are responsible for in Copayments, Coinsurance or Deductible charges. In addition, in no instance will the maximum benefit per person per Benefit Cycle exceed $5,000.

Any remaining funds at the end of the Benefit Cycle will not be rolled over into the next Benefit Cycle.

Eligible expenses are charges incurred for medically necessary outpatient services from psychiatrists, psychologists, nurse practitioners or licensed clinical social workers providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental, behavioral, and substance use disorders. Eligible expenses also include electroconvulsive therapy for treatment of mental or behavioral disorders, as well as treatment provided by a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law or is approved by the Joint Commission on the Accreditation of Health Care Organizations if outside of New York. For substance use disorders, eligible expenses also include charges incurred for medically necessary outpatient family counseling services at an outpatient treatment facility. Any family

*Because the Children's National benefit began in the middle of a Benefit Cycle, from January 1, 2023 to June 30, 2023, the reimbursement limit is $2,500 per Employee and eligible dependent. For the Benefit Cycle that began on July 1, 2023 and ends June 30, 2024, and every subsequent Benefit Cycle thereafter, the reimbursement limit will be $5,000 per Employee and eligible dependent.

member covered by the Plan may receive counseling visits. Eligible expenses also include charges for out-of-network outpatient treatment at a facility that offers services appropriate to the employee or dependent's diagnosis and that 1) has New York State certification from the Office of Alcoholism and Substance Abuse Services or 2) is approved by the Joint Commission on the Accreditation of Health Care Organizations if outside of New York.

To make a claim:

In order to receive this supplemental benefit, you must first make a claim for outpatient mental health benefit coverage through Anthem or your participating hospital's mental health benefit coverage. See the *Medical Coverage, Behavioral Health*, and *Medical Claims and Appeals* sections for more information on claims for Anthem benefits generally.

Then, in order to receive this supplemental benefit, you must make a claim for the supplemental benefit and attach the Explanation of Benefits (EOB) received from Anthem or your participating hospital's medical coverage along with a receipt showing proof of payment to the provider. You can find the claim form on the CIR website: visit www.cirseiu.org/benefits and select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod. A separate claim form must be submitted per Employee and eligible dependent.

Claims for this supplemental benefit must be submitted within one (1) year from the date of service.

Appeals

If you are dissatisfied with the outcome of your claim, you can file an appeal directly to the Board of Trustees. Refer to the *Claims and Appeals* section for more information.

VISION BENEFIT

(administered by Davis Vision – Client Code 2189)

In-Network Benefit

The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependent(s) use your in-network benefit you will be entitled to:

- Free eye exam every Benefit Cycle (July 1 to June 30)
- Lenses every Benefit Cycle (see chart below for lens options and co-pay amounts)
- Frames (every other Benefit Cycle) as follows:
    - Any frame from the Davis Vision Fashion Collection will be covered in full OR
    - A $15 Copayment for a Designer frame within the Davis Vision collection of Frames OR
    - A $40 Copayment for any Premier level frames within the Davis Vision Collection OR
    - If you choose a frame that is NOT in the Davis Vision collection, you will receive a $50 allowance toward any frame from the participating provider plus 20% off any balance*
- Contacts every Benefit Cycle (in lieu of eyeglasses):
    - You will receive a $100 allowance plus 15% off any balance* OR
    - Visually required contacts, you will receive a $135 allowance with prior approval

*some limitations apply to additional discounts; discounts not applicable at all in-network providers

Contact Lenses

If you require a contact lens evaluation and fitting, you will receive a 15% discount off the fitting exam when you visit an in-network provider. See above for more information about contacts.

Copayments

Lens Types and Coatings	Copay
Clear Plastic Lenses (single, bifocal, trifocal)	$0
Scratch Resistant Coating	$0
Premium Scratch Resistant Coating	$30
Tinting of Plastic Lenses	$15
Polycarbonate Lenses	$0*-35
Ultraviolet Coating	$15
Intermediate Vision Lenses	$30
Standard Progressives	$65
Premium Progressives	$105

Ultra Progressives	$140
Ultimate Progressives	$175
Plastic Photosensitive Lenses	$70
Digital Single Vision Lenses	$30
Polarized Lenses	$75
Standard Anti-Reflective (AR) Coating	$40
Premium AR Coating	$55
Ultra AR Coating	$69
Ultimate AR Coating	$85
High-Index Lenses 1.67	$60
High-Index Lenses 1.74	$120
Scratch Protection Plan Single Vision	$20
Scratch Protection Plan Multifocal Lenses	$40
Trivex Lenses	$50
Blue Light Filtering	$15

*Polycarbonate lenses covered in full for dependent child(ren), monocular patients, and patients with prescriptions 6.00 diopters or greater

Participating Providers

To locate a provider in the Davis Vision network, log on to the Open Enrollment section at www.davisvision.com and enter client code **2189**. To use your in-network benefits, present your Davis Vision Member ID card or give the provider your client code (2189) and your first and last name.

Can I split my benefits?

You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value, we recommend that all services be obtained from an in-network provider.

Out-of-Network Benefit

You may receive services from an out-of-network provider; however, you will receive the greatest value when you go in-network. If you choose an out-of-network provider, you will receive a maximum of $40 per Benefit Cycle year toward an eye exam and $60 per Benefit Cycle toward materials. You must pay the provider directly and file a claim with Davis Vision to be reimbursed.

Claims must be filed within 365 days of the date of service.

Claims should be mailed to:

Vision Processing Unit
PO Box 1525
Latham, NY 11210

Exclusions

This vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described in this section; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same Plan Year; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

Other Benefits

Davis Vision also provides discounts on laser vision correction and replacement contacts through LENS123©, a mail-order contact lens service. Visit davisvision.com for more information or contact Davis Vision at (877) 923-2847.

One Year Breakage: Warranty Repair or replacement of your plan-covered spectacle lenses, collection frame or frame from an in-network retail location where the Collection is still available. If your selected lenses, collection frame or frame is not available, Davis Vision will replace with another item from the same tier.

Additional Savings: Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount (some limitations apply to additional discounts; discounts not applicable at all in-network providers).

Laser Vision Correction: Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com

How can I contact Member Services?

Call (800) 999-5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m., Saturday, 9 a.m.-4 p.m., Sunday, 12 p.m.-4 p.m. (ET). (TTY services: (800) 523-2847.)

Appeals

Appeals for vision benefits must be directed to Davis Vision. Your Internal Appeal must be made in writing within 180 days after you receive notice of denial. Call Davis Vision Quality Assurance at (888) 343-3470 or address your complaint, grievance or appeal to:

Davis Vision Inc.
Attention: Quality Assurance/Patient Advocate Department
PO Box 791
Latham, NY 12210

EMPLOYEE ASSISTANCE PROGRAM

Balancing your work and home is not always easy. Uprise Health is a confidential employee assistance program ("EAP") through Guardian, **free to you and your family**. You don't have to face life's challenges alone. Uprise Health provides support and guidance for matters that range from personal issues you might be facing, to providing information on everyday topics that affect your life.

Services can be for everyday issues, or those related to a crisis. Services may be accessed 24 hours a day, 7 days a week. Services include, but are not limited to, face-to-face counseling of up to 3 visits per issue; unlimited counseling by telephone; access to Work/Life specialists; child and elder care referral; and employee discounts (see below).

To access confidential services, contact Uprise Health at (800) 386-7055 or eapcounselor@uprisehealth.com. Services may also be accessed on the Uprise Health website, www.worklife.uprisehealth.com, access code: "worklife."

The EAP can offer support with:

Lifestyle & Fitness Management	**Working Smarter**
• Anxiety and depression	• Balancing work and home life
• Divorce and separation	• Career & training development
• Relationship issues	• Effective managing
• Drugs and alcohol	• Relocation
• Grief & loss	• Workspace diversity
• Health and well-being	
• Pet care	

Support and guidance are just a phone call away.

These comprehensive EAP services are available for each employee and eligible dependent. If an enrolled employee did not enroll any dependent(s), the dependent(s) in the employee's household, including spouse or domestic partners, are still eligible for the EAP. For dependent child(ren), EAP services are only available from ages 7 through 26.

The "Perks at Work" program provides discounts on goods and on-demand classes. To access these services, visit worklife.uprisehealth.com, with access code "worklife."

All services and products are provided solely by Uprise Health and its contractors, which are unaffiliated to Guardian. Guardian is not responsible for care or advice given by any provider or resource provided under this program. There is no additional charge above the premium VHHSBP pays Guardian for these services.

If VHHSBP no longer offers the Long-Term Disability plan as a benefit, access to the EAP services ends for VHHSBP and for all persons covered under the plan. Guardian reserves the right to terminate, modify or replace any program at any time.

HEARING AID BENEFIT

(Self-Insured)

Eligibility

VHHSBP will only cover you and/or your dependent(s) when services are provided in-network by EPIC Hearing Health Care.

Maximum coverage allowed: A lifetime maximum of $1,500 per ear to cover the cost of a hearing aid.

VHHSBP will cover you and/or your eligible dependents when services are provided by EPIC Hearing Health Care or will reimburse you a lifetime maximum of $1,500 per ear.

Using an In-Network EPIC Hearing Provider

Contact EPIC toll free at (866) 956-5400 and identify yourself as a CIR-Voluntary Hospital House Benefits Plan Member.

To obtain your hearing benefits, follow these steps:

1. EPIC personnel will register you, and obtain your CIR Member ID* to confirm eligibility with the Benefits Office.
2. Once eligibility is confirmed, a referral will be issued to an audiologist closest to your home or work.
3. EPIC will notify the audiologist of the patient referral and mail you a copy for your records.
4. The audiologist will evaluate the hearing and submit their audiometric results with hearing aid prescription to EPIC.
5. You will receive a plan booklet outlining all plan services and pricing.
6. When you visit your EPIC provider, all benefits will be coordinated for you, and you will only need to pay for services that exceed the $1,500 per ear lifetime allowance. You will not need to file a claim for reimbursement.

You and/or your eligible dependents are entitled to a 45-day trial period. Once you accept the device at the completion of the trial period, EPIC will submit a claim to the Benefits Office for payment.

EPIC offers all makes and models from all manufacturers at 30-60% off MSRP; with prices starting as low as $495. Contact the EPIC Hearing Service Plan toll free Monday - Friday 8:00 a.m. to 8:00 p.m. CST.

*Please note: You may find your CIR Member ID # on your Davis Vision card. If you do not have your ID card or not eligible to receive the ID card, please contact the Benefits Office Monday to Friday during normal business hours.

Appeals

If you are dissatisfied with the outcome of your claim, you can file an appeal to the Board of Trustees. Refer to the *Claim Review and Appeal Procedures* section of this SPD for more information.

QUALITY IMPROVEMENT (QI)/PATIENT SAFETY EDUCATIONAL SCHOLARSHIP BENEFIT

VHHSBP is committed to providing Employees the tools to deliver the best patient care.

QI/Patient Safety Conferences

The Plan will fund a series of QI/Patient Safety Conferences and disseminate QI/Patient Safety resource information. All covered employees will be invited to attend these events and be able to access resources created. There will be no registration fee for eligible covered employees to attend these events or to access QI/Patient Safety resource information.

Patient Safety Education and Training Scholarships

The Plan provides scholarships for eligible covered employees to access approved Quality Improvement and Patient Safety sponsored programs available in the contiguous 48 United States. In order to receive these benefits, you must be pre-approved by the Plan. Once approved, employees will be eligible to receive scholarship benefits of up to $3,000 per Benefit Cycle to cover the expenses related to registration, travel, and tuition at one Patient Safety Education and Training Program per Benefit Cycle. Spouses, domestic partners, and dependent children are not eligible for this scholarship.

Covered employees accessing this benefit are responsible for receiving time off (vacation or education leave time) to attend or participate in these educational opportunities.

Applications to participate in this benefit will be granted on an equitable basis based on completion of the Quality Improvement Training & Education Application Form and criteria developed by the Quality Improvement Director. The application must include an explanation detailing how the applicant will present what they learned at the conference to their hospital colleagues (for example, at grand rounds, departmental presentations, or intern orientation).

Who is Eligible?

Only employees of VHHSBP participating employers who will be employed by the VHHSBP participating employer in the following academic year; in other words, you must have at least one academic year left in your residency program to be eligible. Employment requiring rotation to a non-VHHSBP hospital will render you ineligible for this benefit.

Covered Expenses Following Approval

The following expenses are eligible for reimbursement when incurred in conjunction with a pre-approved QI program:

- Expenses related to program registration or tuition
- Reasonable lodging or hotel expenses (if travel is overnight or long enough that you need to stop for sleep or rest)

- The costs of transportation between your home (residency program location) and the QI location (travel by airplane, bus, or car; airplane travel subject to the restrictions below)
- Car expenses (mileage, tolls, parking, and costs of rental, if necessary)
- Poster(s)/Abstract Submission(s)
- Meals and incidental expenses (including amounts for food, beverage and tips) when traveling to conferences away from home up to the following limits:
  - Up to $15 for breakfast
  - Up to $25 for lunch
  - Up to $35 for dinner

Expenses that are not covered:

- *Acela* Amtrak train or Business Class travel
- Room service
- Pay per View movies
- Alcohol and bar expenses
- Expenses for costs incurred by spouse or dependent(s)
- Other personal expenses

Submission Rules

Prior to attendance, you must first submit, and the Plan must approve, your application. See more information under the "How to Apply" section below. Applications to participate in this benefit will be granted on an equitable basis.

Once you have attended or participated in the approved event, you will have ninety (90) days to fulfill the requirements set forth in your application. These requirements are: posting your findings on the CIR Gateway site, www.qigateway.org, and presenting the content learned from the program to your department or hospital colleagues.

You must complete the reimbursement form for your eligible expenses within one (1) year of the date of purchase.

How to Apply

You can find the application form on the CIR website. Visit www.cirseiu.org/benefits and select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- **You must submit your application at least six (6) weeks prior to the program date.**
- The application must include an explanation detailing how you will present what you learned at the program to your department or hospital colleagues (for example, at grand rounds, departmental presentations or intern orientation).

- If you are a first-time applicant, with your application you must submit your curriculum vitae (two-page maximum), a personal statement highlighting your interest in patient safety and why attending this program would complement that interest (one-page maximum), and a letter of support from a faculty member that highlights your leadership and patient safety engagement.
- If approved, you are responsible for receiving time off (vacation or education leave time) from your participating employer to attend or participate in these educational opportunities; this benefit will not provide any shift coverage.

Guidelines for Reimbursement:

You must receive an approval letter from the Plan prior to booking any necessary travel. All travel must be booked through UN Travel. Please see further instructions below under "Transportation Reimbursement Guidelines."

Once you have attended the previously-approved event, the Plan will reimburse your actual, documented expenses for the items listed above under "Covered Expenses" up to the stated limits (if any). If you spend more than the limits, you will not be reimbursed the difference between the limits and the amount you spent. In order to be reimbursed, you must provide proof of attendance and proof of payment for all eligible expenses to the Benefits Office with your claim form. Examples of acceptable proofs of attendance include ID badges, program agendas, or certificates of program completion. No claims will be processed prior to proof of attendance at the program or program completion.

Receipts must be submitted for **all** eligible purchases and date of purchase must be on receipt. Please upload **scanned copies or clear photos/images** of your receipts as requested on the claim form. The Plan reserves the right to request original receipts.

Reimbursement claims must be submitted to the Benefits Office within one (1) year from date of purchase.

Transportation Reimbursement Guidelines

- Employees must travel in economy or coach class; VHHSBP will not reimburse Employees for any upgrades (example: coach to business class) or travel by Amtrak Acela train.
- Employee MUST reserve tickets by contacting UN Travel (800) 234-8685 or (215) 922-4671.
- Tickets purchased through UN Travel are charged directly to VHHSBP.
- Your travel reservation will officially be booked only when you respond to UN Travel's email within 24 hours to accept your initial itinerary and receive a confirmation message from UN Travel with your final itinerary.
- If you are traveling from a different location other than your home (your residency program location) to a conference, and the cost of the fare is more than the round-trip fare to and from your home, you will be responsible to pay the difference in the cost of travel, as determined by UN Travel, at the time of booking.

- All travel changes, such as changing departure/arrival airport or station, flight/train time, etc., must be approved in advance by UN Travel and will only be reimbursed when the change is due to work-related circumstances.

- UN Travel will need the following information from you to book:

    1. Your name as it appears on your driver's license or passport
    2. Date of birth
    3. Gender
    4. Cell phone number
    5. Email Address
    6. Departure airport or train station (city and state)
    7. Arrival and departure dates and times for travel
    8. Frequent Flyer Number and preferred airline (if any) or Amtrak Rewards number (if any)
    9. TSA Number (if applicable)

Appeals

If your scholarship is denied, you will receive an email or notice stating the basis for the denial within 90 days after the submission of the claim. If you are dissatisfied with the outcome of your claim, you can file an appeal directly to the Board of Trustees. Refer to the *Claims and Appeals* section for more information.

Recommended Programs:

A list of recommended programs is below:

American Association of Medical Colleges (AAMC) Integrating Quality Conference
Association for Graduate Medical Education (ACGME) Annual Conference
Agency for Healthcare Quality and Research (AHRQ) Annual Conference
American College of Medical Quality (ACMQ) Annual Meeting
Annual Quality and Safety Educators Academy (QSEA)
Beyond Flexner

Institute for Healthcare Improvement (IHI) Annual National Forum on Quality Improvement in Healthcare, or other IHI events
In-Hospital Programming Online Curriculum & QI Gateway Conference
Lown Institute Annual Conference
National Association for Health Quality (NAHQ) Annual Educational Conference
National Patient Safety Foundation (NPSF) Conference
National Quality Forum (NQF) Annual Conference
Society of Teachers of Family Medicine (STFM) Annual Spring Conference
SQUIRE International Conference
Telluride Patient Safety Roundtable

SHORT-TERM DISABILITY BENEFITS

INTRODUCTION

The Plan provides you with income during a period of disability due to a non-occupational accident or illness.

Short-Term Disability Benefits are available for the employee only. If you become disabled while eligible for benefits under the Plan, Short-Term Disability Benefits begin on the 8th calendar day of a non-occupational disability.

The maximum benefit payable is the greater of any state-mandated minimum or 60% of your weekly salary, up to a maximum of $692 per week. Your payment may come from different sources depending on the state in which you are employed, as discussed later in this section, and can include a statutory benefit as well as a Supplemental Short-Term Disability Benefit. The Supplemental Short-Term Disability Benefit payable by the Plan is the benefit amount above any statutory benefit provided by the state in which you are employed (if applicable) up to the maximum of $692 per week.

DEFINITION OF DISABLED

"Disabled" means you are unable to work as a result of accidental bodily injuries, sickness, or pregnancy and are thereby prevented from performing the duties of your occupation and you are under the care of a legally licensed provider as defined by the state in which you work.

DURATION OF BENEFITS

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks. Payment of weekly benefits ends on the **earlier** of:

1. The date on which you are no longer disabled; or
2. After 26 weeks of disability benefits have been paid.

No benefits will be paid prior to the 8th calendar day of disability or for more than 26 weeks. If your Disability extends beyond 26 weeks, you may be eligible for Long Term Disability.

LIMITATION ON DISABILITY

During any period in which you are able to perform any work for remuneration, you will not be considered disabled under this Plan and no benefits will be paid. Benefits will only be paid for periods during which you meet the definition of "disabled."

REDUCTION OF BENEFITS

While receiving Short-Term Disability Benefits, you may receive other income. If so, the Short-Term Disability Benefits you would otherwise receive will be reduced by any such income. Such income may include, but is not limited to:

- No-Fault wage replacement;
- Other statutory benefits; or
- Any amounts you receive for paid time off from your employer.

If you are eligible for a no-fault wage-replacement or other statutory benefits, you **must** apply for such benefits and provide documentation showing approval of the benefit, the amount of the benefit paid, and the duration of the benefit with your application.

EXCLUSIONS

No benefits will be paid with respect to:

- Disabilities for work-related illnesses or accidents covered by Workers' Compensation or any other similar state or federal law;
- Any period during which you perform any work for remuneration or profit; or
- Any claim that is not filed within 60 days of the start of the first date of the disability unless circumstances prevent you from filing the claim in a timely manner, in which case, claims must be filed within 26 weeks of onset of disability.

FILING A DISABILITY CLAIM

When you file a claim for disability, you must provide proof of your disability.

- You must be under the care of a legally licensed physician, dentist, psychologist, podiatrist, nurse-midwife or chiropractor for your claim to be considered.
- This provider must, when requested by the Plan, certify the following: the scope of, the probable duration of, and all medical facts, to the best of his or her knowledge, about your disability.
- The Benefits Office (or Standard Security Life Insurance) will evaluate your claim and determine if benefits are payable.
- The Plan reserves the right to have a physician examines you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

All claims must be submitted within sixty (60) days of the start of your disability. Claims are submitted to Standard Security Life Insurance, if you are employed by a Qualified New York Employer (see below), or to the Benefits Office. The Short-Term Disability Claim Form may be obtained online at www.cirseiu.org/benefits, or by contacting the Benefits Office at (212) 356-8180.

Qualified New York Employer (insured)

If you work for a Qualified New York Employer (defined below in *Qualified New York Employers*), please mail, fax, or email your Short-Term Disability claim to: Standard Security Life Insurance, P.O. Box 25339, Farmington, NY 14425; fax: (585) 398-2854; or email: claims@sslicny.com.

Non-Qualified New York or Out of State Employer (self-insured)

If you work for an employer that is NOT a Qualified New York Employer (e.g., New Jersey and Massachusetts employers and other New York hospitals who do not participate in the fully-insured program), please return your claim form to the Benefits Office.

NOTICE OF DECISION

A decision on the disability claim will be made and you will be notified of the decision within forty-five (45) days. If an extension of time due to matters beyond the control of the Plan is required, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the forty-five (45) day period. A decision will be made within thirty (30) days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional thirty (30) days, provided the Plan notifies you, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

APPEALS

If a claim for disability benefits is denied, you will be notified by the Benefits Office within the time periods set forth above in *Notice of Decision*. You have the right to appeal as follows:

- If you are employed by a Qualified New York Employer (defined below in *Qualified New York Employers*), you must file an appeal by following the instructions on the Notice of Total or Partial Rejection of Claim for Disability Benefit (the DB-451 Form) sent to you from the Benefits Office. An appeal of the total or partial rejection of your claim for New York State statutory disability benefit is made to the New York State Workers' Compensation Board to the address listed on the DB-451 Form.
- If you are **not** employed by a Qualified New York Employer, refer to the *Claims and Appeals* section of this SPD for more information.

QUALIFIED NEW YORK EMPLOYERS

Qualified New York Employers are hospitals in New York State that agreed to have the VHHSBP provide the New York State Mandated Disability Benefit as well as supplemental benefits above the statutory minimum. Currently the Qualified Employers are:

1. One Brooklyn Health (formerly Brookdale University Hospital and Medical Center, Interfaith Medical Center, and Kingsbrook Jewish Hospital)
2. Institute of Family Health – Harlem
3. BronxCare Health System
4. Wyckoff Heights Medical Center
5. St. Barnabas Hospital
6. Brooklyn Hospital Center

7. Flushing Hospital Medical Center
8. New York Methodist Hospital
9. Jamaica Hospital
10. Maimonides Medical Center
11. St. John’s Episcopal Hospital
12. Mt. Sinai Morningside West

LONG-TERM DISABILITY

(Insured by The Guardian Life Insurance Company of America – Group # 348566)

The following provides a quick guide to the Long-Term Disability (LTD) plan. It is not a complete description but a summary. You can review the full terms and conditions of this benefit by requesting the Long-Term Disability Certificate of Coverage from the Benefits Office.

Elimination Period (a.k.a. Waiting Period)

For long-term disability due to injury or illness, the waiting period is 180 calendar days. Note that Supplemental Short-Term Disability may cover the first 26 weeks after the onset of an illness or accident.

Gross Monthly Benefit

60% of your prior monthly earnings, rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $3,500.00. **Note:** Guardian integrates your gross monthly benefit with certain types of other income you may receive. Read all of the terms of the Certificate of Coverage to see what income Guardian integrates with, and how.

Maximum Payment Period

For a disability starting before the employee reaches age 60, you can potentially receive monthly payments until the Social Security Normal Retirement Age (65). If the disability period starts when or after the employee reaches age 60, LTD payments will continue based on age at the time of disability. For example, if the LTD begins at age 60, the maximum period will be 5 years. Should the LTD begin at age 69, the maximum period will be 1 year.

Application for Other Income Required

You must apply for any other disability, income replacement or retirement benefits with which Guardian integrates and which Guardian feels you, your spouse, or dependent child(ren) may be entitled to receive as outlined in the Certificate of Coverage, including, but not limited to, commissions, statutory disability benefits, other disability benefits under a group plan, other disability income under a group plan, sick leave, or salary continuation income. If such benefits are denied, Guardian requires you to re-apply/appeal said denial. You are required to continue with any appeals process until: (a) you receive written notification from Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If Guardian feels that you are entitled to any of the benefits noted above, Guardian will: (a) assume you are receiving such benefits; and (b) integrate the gross monthly benefit with the estimated amount of such benefits payable to you and any applicable dependent(s) on behalf of your disability. But Guardian does not do this if you sign Guardian's agreement concerning benefits under which you promise: (a) to apply for any benefits Guardian integrates with; and (b) at Guardian's request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any compulsory benefit act or law; (ii) retirement benefits or retirement plan disability benefits under any other government plan

which you receive as a result of your disability; and (iii) benefits from a Workers' Compensation law, an occupational disease law, or any other act or law of like intent. If Guardian estimates them, they adjust your net monthly payments when they receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals Guardian requires. In the case of (b), if such adjustment shows Guardian underpaid you, they will pay you the full amount of the underpayment in a lump sum.

Computing Your Net Monthly Benefit and Net Monthly Payment from This Plan

Your net monthly benefit under this plan is your gross monthly benefit, as determined on your initial date of disability, integrated with any other income with which this plan integrates that you receive or are entitled to receive. To compute your net monthly benefit under this plan: (a) determine your gross monthly benefit as shown above; and (b) from the gross monthly benefit, subtract the sum of all of the income with which Guardian integrates that you receive or are entitled to receive. The result is your net monthly benefit.

Your net monthly payment under this plan is your net monthly benefit determined above, reduced by 50% of any current monthly earnings you earn while disabled. If, during any month for which this plan pays benefits, the sum of the following: (a) your net monthly payment, as figured above; (b) the total amount of all other income with which this plan integrates that you receive or are entitled to receive; and (c) the amount of your current monthly earnings; is greater than the amount of your indexed prior monthly earnings, your net monthly payment for that month will be further reduced by that portion in excess of 100% of your indexed prior monthly earnings. This will not apply during any period of time that you are an employee in a Guardian rehabilitation program, as described in this plan, and have signed a valid rehabilitation agreement with Guardian.

Waiver of Premium

Guardian waives all premiums for your LTD income insurance which fall due while you are entitled to receive a net monthly payment from this plan.

Rehabilitation Benefits under This Plan

If you are disabled under this plan and meet selection criteria as established by Guardian, you may be selected to enter into a rehabilitation agreement with Guardian. This agreement starts when: (a) Guardian informs you in writing that you have been accepted into the rehabilitation program; and (b) you agree in writing to participate in the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this plan. This includes during this plan's elimination period. The exact terms of the rehabilitation agreement may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and prior monthly earnings.

If you are chosen for a rehabilitation agreement, you will be entitled to an enhanced benefit based on 110% of the net monthly payment to which you would have been entitled had you not entered into the rehabilitation agreement. If you are chosen for such an agreement with Guardian, you will continue to be subject to all the terms of this plan. The enhanced benefit will start on the later of: (a) the effective date shown on the rehabilitation agreement; or (b) the date you complete the

elimination period. Your eligibility for the enhanced benefit will extend until the earliest of: (a) the date you are no longer disabled under this plan; (b) the date you earn or are able to earn at a rate of at least 80% of your indexed prior monthly earnings; (c) the date you die; (d) the end of this plan's maximum payment period; (e) the date you violate any of the terms of the rehabilitation agreement; (f) the date you elect to end the rehabilitation program; or (g) the date the rehabilitation agreement expires.

If you end a rehabilitation agreement on a basis that is not agreeable to Guardian, you may be required to repay any benefits paid that are in excess of what this plan would have paid had you not participated in the rehabilitation agreement. There are additional advantages available to an employee who participates in a rehabilitation agreement as described above. For more information on these incentives and how you may become eligible to receive them, contact the Guardian rehabilitation specialist.

Special Limitations, Mental or Emotional Conditions, Alcohol Abuse and Drug Abuse

If you are disabled, as defined by this plan, by a mental or emotional condition, alcohol abuse or drug abuse, Guardian limits this plan's benefits. For the long term disability income coverage of this plan, a mental or emotional condition will include, but is not limited to, any of the following: bipolar affective disorder (manic depressive syndrome), schizophrenia, delusional (paranoid) disorders, psychotic disorders, depressive disorders, anxiety disorders, somatoform disorders (psychosomatic illness), eating disorders, mental illness.

For each disability due to a mental or emotional condition, alcohol or drug abuse, Guardian's payments stop at the earliest of: (a) the date during any one period of disability that you have received 60 net monthly payments; (b) the end of the maximum payment period; or (c) the date disability ends. Also, payments will be limited to a total of 60 months in your lifetime for all disabilities contributed to, or caused by, any and all of the conditions shown above. But, if at the end of benefit payments, you are being treated for the cause of your disability as an inpatient in a qualified institution for at least 14 consecutive days, Guardian extends the payments. Guardian extends them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the maximum payment period; or (c) the date disability ends. By "qualified institution," Guardian means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your disability.

Pre-Existing Condition

A pre-existing condition is a sickness or injury, including all related conditions and complications, for which, in the three months before your insurance under this plan starts, you: (a) receive advice or treatment from a doctor; take prescribed drugs; or receive other medical care or treatment, including consultation with a doctor; or (b) exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. A pregnancy which exists on the date your insurance under this plan starts is also a pre-existing condition. Guardian does not cover disability caused by such a condition until the later of: (i) the day following the date you are insured under this plan for at least 12 consecutive months; and (ii) the date benefit payments would otherwise start in the absence of this provision.

Guardian does not cover any disability which begins before your insurance under this plan starts.

Exclusions

Guardian does not cover any period of disability caused, directly or indirectly, by: (a) declared or undeclared war or act of war or armed aggression; (b) your service in the armed forces, National Guard, or military reserves of any state or country; (c) your taking part in a riot or other civil disorder; (d) your commission of, or attempt to commit, a felony; (e) your being engaged in an unlawful occupation; or (f) intentional self injury or attempted suicide.

Guardian does not pay benefits for any period during which you are not under the regular care or treatment of a doctor.

Guardian does not pay benefits for any period of disability which starts before you are insured by this plan.

No benefits will be payable for any period during which your loss of earnings is not solely due to your disability.

Converting Your Group Long Term Disability Income Insurance

Eligibility for Conversion

When your coverage under this group LTD income plan ends, you may obtain a converted individual disability income policy, subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not disabled under the terms of this LTD plan; (b) have been covered under this LTD plan (or a prior group disability income plan which this plan replaced) for at least twelve (12) consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to Guardian in writing within forty-five (45) days after the date on which your coverage under this LTD plan ends. By "residency program," we mean a program of internship or residency in a medical specialty, accredited by the American Council for Graduate Medical Education.

But you will not be eligible for a converted individual disability income policy if your group LTD coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this LTD plan; (c) fail to complete a program of residency; (d) retire; (e) because coverage ends for all persons or all persons in a class under this LTD plan.

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within forty-five (45) days after the date that this group coverage ends. Guardian will not issue a converted individual disability income policy if such policy would result in your being overinsured by our standards.

To Obtain a Converted Individual Disability Income Policy

You must apply to Guardian in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within forty-five (45) days of the date on which your group LTD coverage ends. If you fail to apply to us in writing and pay any required

premium within forty-five (45) days of the date your group LTD coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

The Converted Individual Disability Income Policy

Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group LTD plan ends. The benefits, terms and conditions of the converted individual disability income policy will be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group LTD plan.

How Much Will This Individual Policy Cost?

The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

LONG TERM DISABILITY CLAIMS AND APPEALS

Claim Filing

You must send Guardian written notice of an injury or sickness for which you intend to file an LTD claim within 30 days of the injury or start of the sickness for which a claim is being made. This notice should include your name and Social Security number and the plan number Group # 348566. You will be furnished with claim forms for filing proof of disability within 15 days of Guardian's receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to the Benefits Office within the time set forth below in the section titled *Time Limit for Filing a Long-Term Disability Claim*.

If you are not furnished with the forms within the time stated, Guardian will accept a written description of the injury or sickness that is the basis for the claim in place of Guardian's form. You must detail the nature and extent of the disability for which the claim is being made. If necessary, to determine liability, as part of proof of loss, Guardian may require:

a. Certification of the extent and nature of your disability from all doctors who have treated you for the cause of your disability;

b. Certification of income from any other sources of income to which you may be entitled which may affect Guardian's benefit payments;

c. Satisfactory evidence that you have applied for all benefits and payments from other in-come sources to which you may be entitled; and

d. Proof of any income from other sources that you have received.

Guardian may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of Long-Term Disability benefit payments until such information or authorization is received by Guardian.

Time Limit for the Filing of a Claim

You should file a claim as soon as possible; you should not wait to file a claim until the elimination period has passed. Any claim not filed within a reasonable period of time following the end of the elimination period (26 weeks) will be denied and no Long Term Disability benefits will be payable unless Guardian receives written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year (1) retroactively from the date the claim is filed.

Continued Proof of Disability

Additional proof will be required. Written proof of your continued disability and doctor's care must be provided to Guardian within 30 days of each date Guardian makes such request.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 45 days after receipt of the claim.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Appeal for Long-Term Disability

If your claim for Long-Term Disability benefits is denied, a request for review of the adverse benefit determination may be filed by making an appeal directly to Guardian. The appeal must be made in writing within 180 days after you receive notice of denial.

Appeals for Long-Term Disability should be directed to Guardian at:

Guardian
P.O. Box 4391
Woodland Hills, CA 91367

Guardian will notify you of its decision within forty-five (45) days of your written request for review. If special circumstances require an extension of time for a decision on review, the review period may be extended by an additional forty-five (45) days (or ninety (90) days in total). Guardian will notify you in writing if an additional 45-day extension is needed. A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

REQUIRED DISCLOSURE STATEMENT
For Group Plan No.: G -00348566-HN

This section is a summary of the benefits this plan provides. These benefits, including any exclusions and limitations, are fully outlined in the Guardian Basic Life and Long Term Disability Certificates of Coverage, which should be read along with this SPD for a complete description of your benefits. Please contact the Benefits Office for more details. This Guardian plan provides the following health insurance benefits: Long Term Disability Income Insurance (defined as Disability Income by the New York State Insurance Department). This Guardian plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

EXTENSION OF MEDICAL COVERAGE DURING TOTAL DISABILITY

If your medical coverage ends because your employment terminates, and if on that date you or a covered family member is totally disabled, major medical benefits for the medical condition causing the total disability will continue for the disabled person, subject to the terms and provisions of this Plan. For the purpose of this section only, you will be considered totally disabled if you are unable to perform all of the substantial and material duties of your regular employment or occupation. These extended benefits will be payable as long as that disability continues but not beyond December 31 of the Plan Year following the termination of coverage.

If, during the thirty-one (31) days before your medical coverage ends because your employment terminates, you or a covered family member is under the care of a Physician and disabled, but is not totally disabled, the Plan will cover that treatment for up to three (3) months after your medical coverage ends.

The Plan reserves the right to have the person who is totally disabled or disabled under the care of a Physician examined by a Physician selected by the Plan or its designee at any time during the period that benefits are extended under this provision. The cost of such an examination will be paid by the Plan.

This extension of benefits applies only to the medical coverage.

As an alternative, under certain circumstances, you can choose to continue your coverage but you must pay for the cost of that coverage. For further information, see the *COBRA Continuation Coverage* section.

TERM LIFE INSURANCE

(Insured by Guardian Life Insurance – Group # 348566)

A death benefit of $125,000 will be paid to any beneficiary you name, if you die from any cause while you are covered under this Plan. If you fail to name a beneficiary, this benefit will be paid to your estate. You may name or change your beneficiary at any time. See the *Beneficiary Designation* section below for more information.

Your Term Life Insurance is assignable only to a spouse, parents, grandparents, children, grandchildren, siblings, or the trustee of a trust for the benefit of any of the foregoing individuals.

You must be at work actively on a full-time basis to be eligible for any changes in the terms of this benefit.

Reduction of Basic Life Insurance Amount based on Age:

If you are less than age 65 when your insurance under this plan starts, your insurance amount is reduced, on the date you reach age 65, by 35% of the amount which otherwise applies to your classification and/or option. But in no case will such reduced amount be less than $1,000.00. The preceding reduction also applies to your initial insurance amount if your insurance starts after you reach age 65 but before you reach age 70. If you are less than age 70 when your insurance under this plan starts, your basic life insurance amount is reduced, when you reach age 70, by 50% of the amount which otherwise applies to your classification and/or option. But in no case will such reduced amount be less than $1,000.00. The preceding reduction also applies to your initial insurance amount if his or her insurance starts after you reach age 70.

Limitations for Future Entrants

However, regardless of any of the above reductions, Guardian limits the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70. If you provide Guardian with proof of insurability, and Guardian approves it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $1,000.00. If we do not approve your "proof," your insurance amount will be $1,000.00.

Claims

To make a claim, instructions and the Life Insurance claim form can be found at https://www.cirseiu.org/wp-content/uploads/2018/03/GG42-2017.pdf.

At the time of death, if the beneficiary does not live in the U.S., the beneficiary will need to complete an IRS Form W-8 or W-9.

Claims must be submitted to Guardian at www.GuardianAnytime.com, by clicking on "Secure Channel" on the home page, or by mail or fax at:

Guardian Group Life Claims

P.O. Box 14334
Lexington, KY 40512
Fax: (610) 807-8266
Customer Service: (800) 525-4542

TERM LIFE INSURANCE DURING TOTAL DISABILITY

If you are eligible for benefits under this Plan and you become disabled before you reach age 60, your Term Life Insurance may be continued at no cost to you while you remain totally disabled. This benefit is also called the Extended Life Benefit with Waiver of Premium. You must furnish proof of total disability within one (1) year of the date total disability starts, and as required thereafter. If you die during the first year of total disability, your death benefit will be paid to your beneficiary even if you had not yet furnished proof of the disability. For the purpose of this section only, you will be considered totally disabled only if, due to sickness or injury, you are: (a) not able to perform any work for wages or profit; and (b) you are receiving regular doctor's care appropriate to the cause of disability; unless you have reached your maximum point of recovery, yet are still disabled under the terms of this plan.

Further, in order to be eligible for this extension, you must: (a) become totally disabled before you reach age 60 and while insured by this plan; and (b) remain totally disabled for nine (9) consecutive months. You may apply for this benefit immediately upon the onset of disability.

Guardian requires periodic written proof that you remain totally disabled to maintain this extension. This written proof of your: (a) continued disability; and (b) doctor's care must be provided to us within 30 days of the date we make each such request.

Note: in the event that you receive the Extended Life Benefit with Waiver of Premium nine (9) months after you become disabled, in order for you to maintain your Dependent's Life Insurance coverage, you must convert your dependent's policy to an individual permanent policy.

To make a claim, complete the Application for Waiver of Group Life Insurance Premium claim form and submit to Guardian at www.GuardianAnytime.com by clicking on "Secure Channel" on the home page, or mail or fax to:

Guardian Group Life Claims
PO Box 14334
Lexington, KY 40512
Fax: (610) 807-8266
Customer Service: (800) 525-4542

Accelerated Life Benefit

IMPORTANT NOTICE: use of this benefit may have tax implications and may affect government benefits or creditors. You should consult with your tax or financial advisor before applying for this benefit.

NOTE: the amount of group term insurance is permanently reduced by the amount of the accelerated benefit paid to you.

An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die. If you have a medical condition that is expected to result in your death within six (6) months, you may apply for the Accelerated Life Benefit. The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $50,000.00; or (b) 50% of the in force amount. The maximum benefit amount is the lesser of: (a) $100,000.00; or (b) 50% of the in force amount. The amount paid to you will be subjected to a discount factor and processing fee. Additional details are found in the insurance certificate. This benefit is payable one time only.

Guardian will not pay an Accelerated Life Benefit to you if lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before Guardian pays such benefit to you. To make a claim, complete the Accelerated Group Life Benefit Application claim form and Group Term Accelerated Life Benefit Summary and Disclosure Statement form and submit to Guardian at www.GuardianAnytime.com by clicking on “Secure Channel” on the home page, or mail or fax to:

Guardian Group Life Claims
PO Box 14334
Lexington, KY 40512
Fax: (610) 807-8270
Customer Service: (800) 268-2525

Funeral or Last Illness Reimbursement

Guardian may pay up to $500 of the life insurance benefit to any person who appears to have incurred an expense in connection with your funeral or last illness. Guardian’s liability will be discharged to the extent of the amount paid.

Conversion to an Individual Policy

During the first 31 days following:

- the termination of your employment, or
- the group policy providing your Group Term Life Insurance ends, or
- the amount of your insurance is reduced by amendment,

You may convert your Group Term Life Insurance to one of a number of Guardian individual life insurance policies up to the amount of the coverage you lost. You must apply in writing for a conversion policy and pay the first premium within 31 days after your insurance ends or is reduced. You will not have to furnish evidence of good health. The policy will be effective at the end of the 31-day period, and the premiums will be based on current individual policy premium rates. If you die during the 31-day period, your death benefit will be paid whether or not you have applied for an individual policy.

For more information on conversion, and an explanation of the difference between porting and converting your life insurance, please visit https://www.cirseiu.org/wp-content/uploads/2021/06/Portability-vs-Conversion_11.2.pdf.

To make a claim, mail, fax, or email the claim form to:

Guardian
National Conversion Department
PO Box 8070
Appleton, WI 54912-8070
Fax: (920) 749-6219
Secure email: national_conversions@glic.com

Beneficiary Designation

You may change your beneficiary at any time. You can find the Beneficiary Designation/Change Form on the CIR website, www.cirseiu.org/benefits, or on the Member Portal at https://cirmp.novus-360.com/cirmpprod. If you designate more than one beneficiary and fail to specify each beneficiary's share, each beneficiary will receive equal shares. If your beneficiary dies before you do, his or her share will be shared equally by any beneficiaries that survive you, unless you indicate otherwise. If all your beneficiaries die before you do, or your life insurance benefit amount cannot otherwise be disposed of, the amount will be payable to your estate un-less you made a gift assignment.

LIFE INSURANCE CLAIMS AND APPEALS

See specific instructions for making claims in each section above. Claim forms and instructions may be obtained from Benefits Office or Guardian's website: www.GuardianAnytime.com.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. In addition to the basic claim procedure explained in the Certificate of Coverage, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA").

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.

b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Guardian expects to render the final decision.

c) If a claim is denied, Guardian will provide a notice that will set forth:

    1. the specific reason(s) the claim was denied;

2. specific references to the pertinent plan provision on which the denial is based;

3. a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;

4. an explanation of the plan's claim appeal procedure.

Appeals for Life Insurance Claims

If your claim is a Guardian Life Insurance claim, your appeal must be made within sixty (60) days of Guardian's adverse benefit decision. Guardian will notify you of its decision not later than sixty (60) days after receipt of the appeal. If special circumstances require an extension of the time for processing, Guardian will render a decision as soon as possible but not later than 120 days after receiving your appeal. Guardian will notify you about any extension of time.

If your claim is a Guardian Waiver of Premium claim, your appeal must be made within 180 days of Guardian's adverse benefit decision. Guardian will notify you of its decision not later than forty-five (45) days after receipt of the appeal. If special circumstances require an extension of the time for processing, Guardian will render a decision as soon as possible but not later than ninety (90) days after receiving your appeal. Guardian will notify you about any extension of time.

Mail appeals to:

The Guardian Life Insurance Company of America
Attn: Appeals Department
PO Box 14334
Lexington, KY 40512

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00348566-HN

This section is a summary of the benefits this plan provides. These benefits, including any exclusions and limitations, are fully outlined in the Guardian Basic Life and Long Term Disability Certificates of Coverage, which should be read along with this SPD for a complete description of your benefits. Please contact the Benefits Office for more details. This Guardian plan provides the following health insurance benefits: Long Term Disability Income Insurance (defined as Disability Income by the New York State Insurance Department). This Guardian plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

By law, the value of your life insurance over $50,000 must be included in your taxable income. You will be notified of the amount by your employer.

TERM LIFE INSURANCE FOR YOUR DEPENDENT SPOUSE OR REGISTERED DOMESTIC PARTNER

(Insured by Guardian Life Insurance)

A death benefit of $20,000 will be paid to you if your legal spouse or registered domestic partner dies from any cause while covered under this Plan.

CONVERSION TO AN INDIVIDUAL POLICY FOR A SPOUSE

During the first 31 days following:

- the Term Life Insurance for your Dependent(s) Spouse or Registered Domestic Partner ends, or

- the amount of the Term Life Insurance for your Dependent(s) Spouse or Registered Domestic Partner is reduced by amendment, your spouse or registered domestic partner may convert such life insurance to one of a number of Guardian individual life insurance policies up to the amount of coverage lost without the need to furnish evidence of good health. Your spouse or registered domestic partner must apply in writing for a conversion policy and pay the first premium within 31 days after his/her insurance ends or is reduced. The policy will be effective at the end of the 31-day period, and the premiums will be based on current individual policy premium rates. If your spouse or registered domestic partner dies during the 31-day period, this death benefit will be paid whether or not your spouse or registered domestic partner has applied for an individual policy.

Refer to the Certificate for additional details and restrictions.

In the event that you, the employee, become totally and permanently disabled and you apply for and receive the Extended Life Benefit with Waiver of Premium, life insurance for your spouse or registered domestic will terminate. In order to maintain the coverage of your spouse or domestic partner, you must convert the coverage to an individual policy.

If your dependent is confined for medical care or treatment either in an institution or at home on the date this dependent's life insurance would otherwise go into effect, or on the date any adjustment to the benefit amount would become effective, then your dependent's insurance will be deferred until his/her release from medical or home confinement or until the dependent resumes the normal activities of someone of like age and sex.

For additional details, contact the VHHSBP Benefits Office at benefits@cirbenefitfunds.org or by phone at (212) 325-8180. By law, when you receive this benefit for your spouse or domestic partner, you will be taxed on the value of the coverage. You will either receive a separate tax form from your employer or the value will be added to your IRS Form W-2.

Claims

Claims must be submitted to Guardian at www.GuardianAnytime.com, by clicking on "Secure Channel" on the home page, or by mail or fax at:

Guardian Group Life Claims
P.O. Box 14334
Lexington, KY 40512
Fax: (610) 807-8266
Customer Service: (800) 525-4542

Appeals

If your claim is a Guardian Life Insurance claim, your appeal must be made within sixty (60) days of Guardian's adverse benefit decision. Guardian will notify you of its decision not later than sixty (60) days after receipt of the appeal. If special circumstances require an extension of the time for processing, Guardian will render a decision as soon as possible but not later than 120 days after receiving your appeal. Guardian will notify you about any extension of time.

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00348566-HN

This section is a summary of the benefits this plan provides. These benefits, including any exclusions and limitations, are fully outlined in the Guardian Basic Life and Long Term Disability Certificates of Coverage, which should be read along with this SPD for a complete description of your benefits. Please contact the Benefits Office for more details. This Guardian plan provides the following health insurance benefits: Long Term Disability Income Insurance (defined as Disability Income by the New York State Insurance Department). This Guardian plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

ANCILLARY DEATH BENEFIT

(Self-Insured)

This benefit assists in the payment for transporting the remains of a deceased employee or deceased eligible dependent to the place of burial. This benefit will cover up to a maximum of $5,000 for transportation of the remains of a deceased employee to the place of burial if the place of burial is more than 200 miles from New York City.

To make a claim:

At the time notification of the death is made to the Benefits Office, the Benefits Representative will assist the caller with this benefit.

Appeals

If you are dissatisfied with the outcome of your claim, you can file an appeal directly to the Board of Trustees. Refer to the *Claims and Appeals* section for more information.

ACCIDENTAL DISMEMBERMENT BENEFIT

(Self-Insured)

This employee-only benefit will be paid for any of the following losses as the result of an accident occurring on or off the job while you are insured. The injury must have resulted in the loss directly and independently of all other causes and the loss must have occurred within 90 days after the injury was sustained. It is payable in addition to any other insurance for which you may be eligible.

All benefits are payable to the employee, except that any benefit unpaid at your death will be paid to your beneficiary or beneficiaries.

- Loss of sight means total and irrevocable loss of sight. Loss of a hand or foot means loss by severance at or above the wrist or ankle.
- The total payment for all losses due to any one accident will not be more than the full amount of the benefit.

Amount of Benefit Paid To You	For Loss of:
$50,000	Both hands, Both feet, Sight of both eyes, One hand and one foot, One hand and sight of one eye, One foot and sight of one eye
$20,000	One hand, One foot, Sight of one eye

Exclusions

The Accidental Dismemberment Benefit does not cover:

- any loss resulting from war or any act of war (including undeclared war and resistance to armed aggression);
- attempted suicide;
- any loss which results directly or indirectly from bodily or mental infirmity or disease or medical or surgical treatment for such;
- any loss which results from an infection other than a pyogenic infection of an accidental cut or wound;
- any loss which results from travel in any moving aircraft aboard which you are giving or receiving training or have any duties.

Claims

Please contact the Benefits Office to make a claim for the Accidental Dismemberment Benefit. Claims must be filed within 180 days of loss.

Appeals

If you are dissatisfied with the outcome of your claim, you can file an appeal directly to the Board of Trustees. Refer to the *Claims and Appeals* section for more information.

CLAIMS AND APPEALS

How To File Claims for Covered Benefits

Special claims rules may apply to benefits provided under the Plan. Claims determinations are made by the Plan, its insurers or claims administrators. Information about the applicable insurer's or claims administrator's claims procedures can be found in the respective section of this SPD. Make sure you review the sections of this SPD that describe the specific benefit for which you are filing a claim prior to filing your claim.

Follow the instructions contained in each section above to access the relevant claim form and for specific details about making a claim for a particular benefit, including the deadline to make a claim. Claim forms for benefits listed in this SPD, including for benefits self-insured by the Plan (e.g., Hearing Aid, Short-Term Disability, Supplemental Outpatient Mental Health Benefits), may be obtained online at www.cirseiu.org/benefits, or by contacting the Benefits Office at benefits@cirbenefitfunds.org or by phone at (212) 356-8180.

Claim forms for the following may also be obtained by contacting the appropriate insurer or claims administrator as follows: Anthem Blue Cross Blue Shield (Major Medical and Hospitalization), Guardian (Dental, Life Insurance and Long-Term Disability), Davis Vision (Vision Benefits) or Express Scripts (Prescription Benefits). Contact information for the appropriate insurer or claims administrator is in the respective SPD sections or can be found on your ID card.

When completing a claim form, be sure to complete every section. Complete a separate claim form for each employee and dependent. Provide all the information requested on the claim form and enclose all requested documents. Keep copies of all documents sent to the Benefits Office or any insurer or claims administrator.

Time to File Claims

Claims for all benefits provided by the Plan must be submitted in a timely manner in order to receive payment. The time period to file a claim is set forth in the section of the SPD for each type of benefit. If your claim is not filed within the applicable period of time, generally no benefit will be paid.

Policies and Certificates Insurance Contacts Govern

This SPD describes the principal features of the Plan. The complete terms of the Insured coverage are set forth in the insurance policies issued by the insurance carriers. If you would like cop(ies) of any Certificate, you may request them from the Benefits Office. In the event of any question regarding the interpretation of these certificates or the proper payment of benefits, you can obtain information from the Benefits Office. If there is any inconsistency between this SPD and the insurance contracts, the insurance contracts will govern, and they should be read along with this SPD for a complete description of your benefits.

CLAIMS REVIEW AND APPEAL PROCEDURE

Notice of Decision of Denial of Claim

If your claim is denied, whether in whole or in part, you will be provided with written notice of a denial of a claim by the Plan, appropriate insurer or claims administrator. 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 (including voluntary appeals, if any) 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 a statement that the rule is available upon request at no charge.
- 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 the 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.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.
- For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

You will then be entitled, upon written request, to a review of that claim decision. This section describes the procedures followed by the Plan in determining requests for review of disputed claims.

For purposes of this Claims Review and Appeal Procedure, "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit and includes a Rescission of Coverage, whether or not there is an adverse effect on any particular benefit.

Review Process

If you disagree with the decision made on a claim, you may ask for a request for review of the disposition of your claim or adverse benefit determination regarding your claim. The appropriate office and time frames for appeals are summarized in the following chart, and further described below:

Benefit	Time Limit to File Request for Review
Anthem (Medical)	180 days, Internal Level 1 Appeal (filed with Anthem, see page 93) 60 days, Internal Level 2 Appeal (filed with Anthem, see page 94) External Review (if applicable--see *Medical Claims and Appeals*), four months from final determination.
Express Scripts (Prescription)	180 days, Internal Level 1 Appeal (filed with Express Scripts, see page 111) 90 days, Internal Level 2 Appeal (filed with Express Scripts, see page 112) External Review (if applicable--see *Prescription Drug Benefits*), four months from final determination.
Davis Vision (Vision)	180 days (filed with Davis Vision, see page 130)
Guardian (Dental): ManagedDental Guard and DentalGuard Preferred	180 days (filed with Guardian, see page 121)
Guardian • Long-Term Disability • Life Insurance	• 180 days (filed with Guardian, see page 148) • 60 days (filed with Guardian, see page 155)
Hearing Aid	
Accidental Dismemberment	
Ancillary Death	

Supplemental Outpatient Mental Health	180 days (filed with Board of Trustees, see below)
Quality Improvement	
Short-Term Disability • Qualified New York Hospitals • Non-Qualified New York Hospitals	 • 45 days (filed with the New York State Workers' Compensation Board, see *Short-Term Disability*) • 180 days (filed with the Board of Trustees, see below)

Refer to the Claims and Appeals section of each benefit for details on how to file an appeal regarding claims for Medical (including drug coverage), Group Life, Long Term Disability, Dental, and Vision with the applicable carrier or administrator (e.g., Anthem, Express Scripts, Guardian or Davis Vision). For appeals involving Short-Term Disability with a Qualified New York Employer, appeals are sent to the Worker's Compensation Board. Note that time frames to appeal vary depending on the benefit you are claiming.

For self-insured benefits (Hearing Aid, Short-Term Disability (non-Qualified New York employers), Accidental Dismemberment, Ancillary Death, and Supplemental Outpatient Mental Health Benefits), you have 180 days from denial to file an appeal to the Board of Trustees. Refer to *Appeals Process* below.

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 (regardless of whether it was relied upon); it demonstrates compliance with the organization responsible for the claim's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice 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 may be submitted by you.

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

Appeals Process

Please note that there are different processes for the different benefits provided by the Plan.

Appeals for Self-Insured Hearing Aid, Short-Term Disability (non-Qualifying New York employers), Accidental Dismemberment, Ancillary Death, Supplemental Outpatient Mental Health, and Quality Improvement Benefits.

Appeals of adverse benefit determinations regarding the above benefits must be made directly to the Board of Trustees in writing within 180 days after receipt of the adverse benefit determination at:

Board of Trustees
c/o VHHSBP Benefits Office
10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101

You will be notified, in writing, of the decision of the Board of Trustees within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within an additional 60 days. The final decision will be made in writing.

Any claims that involve Disability: ordinarily, decisions on Disability claims will be reached within 45 days of your appeal. However, in special circumstances, up to an additional 45 days may be necessary to reach a final decision on a disability claim. You will be advised in writing within the 45 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision on your claim.

In all communications, be sure to include your identification number and group number.

Short-Term Disability Appeals for Qualifying New York employers must be made to the Worker's Compensation Board. Refer to the *Short-Term Disability* section of this SPD for further details.

Appeals for Dental, Long Term Disability, and Life Insurance Claims (insured by Guardian)

Appeals for denials of Dental, Long Term Disability, and Life Insurance claims are made directly to Guardian. More information about claims and appeals procedures for the above benefits is summarized in the applicable sections of this SPD pertaining to the particular benefit.

Appeals for Medical Benefits (administered by Anthem Blue Cross Blue Shield) and Prescription Drug Benefits (administered by Express Scripts Incorporated, ESI)

All Internal Appeals, as well as all appeals for urgent/expedited claims, should be made by following the procedures set forth in the *Medical Claims and Appeals* section of this SPD (for Medical Benefits) or as set forth in the *Prescription Drug Benefits* section of this SPD (for Prescription Drug Benefits).

Note that you may also be able to request an External Review for Medical Benefits (see the *Medical Claims and Appeals* section) or Prescription Drug Benefits (see the *Prescription Drug Benefits* section).

You will be notified of the decision of the appeal determination in the time frames and manner stated in the *Medical Claims and Appeals* section (for Medical Benefits) and the *Prescription Drug Benefits* section (for Prescription Drug Benefits).

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.
- A statement that if an internal rule, guideline or protocol was relied upon by the Plan, it is available upon request at no charge.
- 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.

ADDITIONAL INFORMATION REGARDING CLAIMS AND APPEALS

A. Medical Judgments

In deciding any appeal based in whole or in part on a medical judgment, the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the adverse benefit determination nor the subordinate of any such individual.

B. Authority of the Plan

VHHSBP (the Plan) is a joint labor-management employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by an equal number of Trustees designated by the participating employers and by the union pursuant to an Agreement and Declaration of Trust, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted a Plan of benefits set forth and described in this SPD. Under the Trust Agreement and this SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and this SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees and other Plan fiduciaries and individuals to whom responsibility of the administration of the Plan has been delegated, whose determinations are final and binding.

C. Discretionary Authority of the Trustees and Their Designees

In carrying out their respective responsibilities under the Plan, the Trustees and other Plan fiduciaries and individuals to whom responsibility of the administration for 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 factual questions related to eligibility for and entitlement to Plan benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

D. Additional Information

If additional information is needed, it will be requested by the appropriate insurer or claims administrator, and absent the timely provision of the information, may require the denial of the claim or appeal.

E. Finality

In deciding claims, the Board of Trustees has broad discretion to interpret and apply the terms of this Plan and SPD.

The determination of the Plan will be final and binding if an objection or request for review is not filed in a timely manner. The decision of the Board of Trustees will be final and binding on any timely appeal presented to it.

The Claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act following an adverse benefit determination on review. If your claim involves disability benefits, you and your plan may have other voluntary alternative dispute options, such as mediation. Contact your local U.S. Department of Labor Office and your State insurance regulatory agency to find out which options are available, if any.

F. Notification and Right to Commentary and Information

Upon any adverse benefit determination, the Plan will notify the Claimant of this claims review and appeal procedure, along with its time limits. A Claimant may review pertinent documents and submit written issues and comments, records or other information relating to the claim. A Claimant shall be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. All comments, documents, records, and other information submitted by the Claimant will be taken into account at any stage of the claims review and appeals procedure and process. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, such will be stated and a copy will be provided upon request. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request. The Plan will provide for the identification of medical or vocational experts whose advice was relied on in connection with an adverse benefit determination.

G. Limitation on When a Lawsuit May Be Started

No lawsuit shall be brought to recover benefits under the Plan unless you have exhausted the appeals procedure outlined above. 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 sixty (60) days have elapsed since you filed a request for review if you have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. If you filed a Voluntary Internal Level 2 Appeal, all deadlines will be tolled until you receive a final decision on that appeal.

Special rules may apply to certain dental benefits.

Any lawsuit must be filed within one (1) year from the date of the final decision.

Call or email the Benefits Office for information.

COORDINATION OF BENEFITS

Important Notice

This section applies to all health benefits which pertain to participating employees and their dependents.

- No individual may be covered under this Plan both as an employee and as a dependent, nor may any dependent(s) child be covered as the dependent(s) of more than one employee.
- In cases where employees are married to each other and have eligible dependent(s), the Plan will designate as primary the employee whose birthday comes earlier in the year.
- The secondary employee will remain as primary for employee-only benefits, such as life insurance and disability.
- Medical, prescription, dental and vision coverage will be covered under the employee.

Purpose

When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense

This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) Deductibles; (b) Coinsurance; and (c) Copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim

This term means a request that benefits of a plan be provided or paid.

Claim Determination Period

This term means a Benefit Cycle. It does not include any part of a year during which a person has no coverage under this plan, or before the date this coverage takes effect.

Co-Pay

The fixed amount you have to pay for service.

Co-Insurance

The percentage you have to pay for services after you meet the deductible (see below) before the insurance company starts paying the cost.

Coordination of Benefits

This term means a provision which determines the order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent

This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Benefit Cycle without regard to any temporary visitation.

Deductible

The dollar amount you have to pay for services before the insurance company starts paying the cost.

In-Network/Out-of-Network

Whether a doctor or Provider is part of the insurance company's "network" (this will change what you pay sometimes).

Plan

This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school accident type coverage or such coverage's issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description. Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan

This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Reasonable and Customary

What the insurance company decides is a normal price for a service. Also called Maximum Allowed Amount for medical coverage.

Secondary Plan

This term means a plan that is not a primary plan.

This Plan

This term means the group health benefits, except prescription drug coverage, if any, provided under this group plan.

Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Non-Dependent or Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Birthday Rule

If a member is married or domestic partner to another member and they have no children, they should both be considered single members as it applies for insurance purposes.

If both members are covered by VHHSBP and/or HSBP, are married or have a domestic partner and have child(ren), then the birthday rule will apply and the member with the earlier birthday (month and day) will have family coverage and the other member will be considered as a spouse. The spouse will only be entitled to coverage that they do not have as a dependent such as disability, the $125,000 life insurance, Professional Educational Benefit, etc.

Child Covered Under More than One Plan

The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

2. If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3. In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active or Inactive Employee

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid

off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage

The plan that covered the person longer is primary.

Other

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But this plan will not pay more than it would have had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan Is Primary

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this Plan. If it does, this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this Plan. This Plan will not have to pay that amount again.

As used here, the term “payment made” includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this Plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

OTHER IMPORTANT INFORMATION AND REQUIRED NOTICES

The Voluntary Hospitals House Staff Benefits Plan of the Committee of Interns and Residents is a group health plan under ERISA and is administered by a Board of Trustees, consisting of an equal number of representatives of the Union and of the voluntary hospital employers. The Plan Administrator is the Board of Trustees.

The names, business titles and addresses of the Trustees are:

Anita Eliot
Director
Committee of Interns and Residents Legal Services
10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101

Susan Naranjo
Executive Director
Committee of Interns and Residents
10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101

Francesca Tinti
Senior Vice President of Human Resources
One Brooklyn Health
1545 Atlantic Avenue
Brooklyn, NY 11213

Bill Lynch
Executive Vice President and Chief Operating Officer
Medisys: Jamaica and Flushing Hospitals
8900 Van Wyck Expressway
Jamaica, NY 11418

The address of the Board of Trustees and VHHSBP Benefits Office is:

10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101
Phone: (212) 356-8180
Fax: (212) 356-8181
Website: www.cirseiu.org/benefits

Service of Legal Process

The Board of Trustees has been designated as the agent for the service of legal process at the address above. Service of legal process can also be made upon a Plan Trustee.

Employer Identification Number

The Employer Identification Number assigned by the Internal Revenue Service is EIN 13-3029280.

Plan Number

The Plan number assigned by the Trustees is 502.

Fiscal Year

For purposes of maintaining the VHHSBP fiscal records, the year-end date is December 31.

Benefit Cycle

The Benefit Cycle begins July 1 and ends June 30.

Funding

Contributions to the Plan are made by the following voluntary hospital employers: Boston Medical Center, BronxCare Health System, Brooklyn Hospital Center, CarePoint Health – Christ Hospital, CarePoint Health – Hoboken University Medical Center, Children's National Hospital, Flushing Hospital Medical Center, Institute for Family Health – Harlem, Jamaica Hospital, Maimonides Medical Center, Montefiore Medical Center (Wakefield), Mount Sinai Morningside West, New York Methodist Hospital, One Brooklyn Health (formerly Brookdale University Hospital and Medical Center, Interfaith Medical Center, Kingsbrook Jewish Hospital), St. Barnabas Hospital, St. John's Episcopal Hospital, Wyckoff Heights Medical Center, CIR and HSBP, in accordance with the Collective Bargaining Agreements between CIR and the employers. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per employee. Employees and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a sponsor of the Plan, the sponsor's address. Employees and dependents may receive from the Plan Administrator, upon written request, a complete list of the employers participating in the Plan.

The Plan is maintained pursuant to Collective Bargaining Agreements or Participation Agreements. A copy of any such Agreement may be obtained by employees and beneficiaries upon written request to the Plan Administrator, and is available for examination by employees and beneficiaries.

Benefits are provided from VHHSBP's assets, which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits for the covered members and dependent(s) and defraying reasonable administrative expenses. Some of these benefits are provided through insurance policies.

VHHSBP's assets and reserves are managed by Stacey Braun Associates, Inc., 377 Broadway, New York, New York 10013. VHHSBP's assets and reserves are invested in equities and investment-grade fixed income securities.

Plan Eligibility

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are fully described beginning at the Eligibility section.

No Liability for Malpractice

The Plan, Board of Trustees or any of their designees are not engaged in the practice of medicine, 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 health care Provider. Neither the Plan, Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Repayment of Benefits

If it is found that the benefits paid by the Plan are in excess of what you were entitled to because:

- some or all of the medical expenses were not paid or payable by you or your covered dependent(s); or

- you or your covered dependent(s) were repaid for some or all of those medical expenses by a source other than the Plan; or

- you or your covered dependent(s) achieve any recovery whatsoever, through a legal action or settlement in connection with any illness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the medical expenses for which Plan benefits were paid; or

- the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, then

The Plan will be entitled to a refund from you of the difference between the amount of Plan benefits actually paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts. For additional information on the procedures that may be followed by the Plan to recover these amounts, see the section entitled "Third Party Liability." The Plan may recover or recoup the amount of any erroneous payment, with interest, by offsetting pending or future benefits in accordance with law and regulation.

Type of Plan

The Plan is a welfare plan and a group health plan.

All types of benefits provided by the Plan are set forth in the *VHHSBP General Benefits Summary* section at the beginning of this SPD.

The complete terms of the insured life insurance and long-term disability coverage are set forth in the group insurance policy with The Guardian Life Insurance Company of America, G-348566.

The complete terms of the insured dental coverage are set forth in the group dental insurance policy with Guardian Insurance Company of America. The Group contract number is 417733 and the Trustees of the Voluntary Hospitals House Staff Benefit Plan is the contract holder. If there is any inconsistency between this SPD and any insurance contracts, the insurance contracts will govern.

Type of Administration

The Medical Benefits are self-insured but administered by Anthem Blue Cross Blue Shield. The Prescription Drug Benefits are also self-insured and administered by Express Scripts Incorporated.

The Dental, Life Insurance, Long-Term Disability, and Employee Assistance Program Benefits are insured by Guardian Life Insurance Company of America.

The Hearing Aid, Short-Term Disability, Accidental Dismemberment benefits, Ancillary Death, Quality Improvement, and Supplemental Outpatient Mental Health Benefits are self-insured and administered directly by the Plan.

Vision benefits are administered by Davis Vision Services.

Limitations and Exclusions

This SPD describes cost-sharing provisions, including Deductibles, Coinsurance and Copayment amounts for which you may be responsible, limits on benefits, the extent to which preventive services are covered, whether and under what circumstances existing and new drugs are covered, coverage provided for medical tests, devices and procedures, limits on obtaining emergency medical care, and any provisions requiring preauthorization or utilization review. Where the Plan utilizes Provider networks, this SPD describes coverage for Out-of-Network services. Lists of In-Network Providers are furnished Anthem (Medical), ESI (Prescription), Dental (Guardian), Davis (Vision), and Hearing Aid (EPIC). Provider lists are furnished, without charge, as a separate document.

This SPD contains circumstances which may result in disqualification, ineligibility or denial of, loss, forfeiture, suspension, offset, reduction or recovery of any benefits.

Insurance Certificates

Guardian Life Insurance Company of America, Guardian Dental, and any other Plan insurers maintain certificates further describing the benefits, limitations and exclusions applicable to these benefits, which apply to the Plan as well. Please see the *VHHSBP General Benefits Summary* for a list of these certificates.

SPD

This SPD is provided in accordance with and subject to the terms, conditions, rules and regulations of the Board of Trustees of the Plan, and the Plan's Agreement and Declaration of Trust. No person is authorized to change or amend this SPD, waive any condition or restriction contained in this SPD, extend any time in this SPD, or bind the Trustees by any statement or promise. No change in this SPD will be valid unless authorized in writing by the Board of Trustees of the Plan.

Examination and Investigation

The Plan shall have the right and opportunity to investigate, at its expense, the person whose injury or sickness is the basis of a claim, when and so often as it may reasonably require during the pendency of the claim under this SPD. You or your personal representative or any other claimant must promptly furnish all consents and authorizations upon request of the Plan to permit its designated representatives to examine any and all medical, hospital and other privileged records and communications relating to any claim filed under this SPD.

Plan Amendment and Termination

The Trustees reserve the absolute right and authority, in their sole discretion, to reduce, modify or terminate the benefit program at any time. Continuation of benefits is not guaranteed. Among other things, this shall empower the Trustees to change the eligibility rules, to diminish the amount of benefits, to increase or require Deductibles, to eliminate particular types of benefits, to substitute certain benefits for others, to impose or decrease maximums on the amounts of benefits payable, and if deemed by the Trustees to be necessary, to require Copayments by employees as a condition for eligibility. The authority of the Trustees to reduce, modify or terminate the benefit program as aforesaid shall extend to active employees and, if retirees are now or hereafter covered to any extent by the benefit program, to retirees.

No individual has a vested right or a contractual interest in the benefits provided under this Plan. In the event of termination of the Plan (which would have to occur if the union and the employers negotiated for discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the Trust Fund to provide benefits or otherwise to carry out the purpose of the Plan in an equitable manner until the entire remainder of the assets has been disbursed. In no event will any part of the assets of the Plan revert to the employers or be paid to the union.

Upon termination of the Plan, the Trustees, with full powers will continue to serve in such capacity for the purpose of and to effectuate the dissolution of the Plan.

THIRD PARTY LIABILITY

Subrogation

If you or any person covered by this Plan as your beneficiary (hereinafter "You" or "covered individual") should suffer an illness or injury, or require medical treatment through the act or omission of someone else or for which a third party may be legally responsible, for which benefits under the Plan's coverage is payable, the following subrogation provisions will apply. If this illness or injury is the result of an accident for which payment may be available from another source, a claim may be submitted for these expenses and payment considered by the Trustees. It is possible that the Plan may advance benefit payment in order to assist you in your time of need. The Plan will have the right to recover any paid benefits from the responsible party. You are required to notify the Plan promptly of any third-party claim you may have for an injury or illness for which the Plan has paid or may pay benefits and any demand made or suit filed against any third party.

In addition, the Plan will have the right to recover any payments which were made to a covered individual and which caused a duplicate payment for the same expenses. The covered individual will cooperate with and assist the Plan in recovering any benefits for which other payment is available and to notify the Plan promptly of any third-party recovery, whether in or out of court, that you, your dependent, or your parents or any agent, representative or trustee or any of them obtains.

The covered individual must reimburse the Plan promptly out of any recovery from any source, including the third party or the third party's insurer, for the benefits paid to the covered individual. The Plan's right to subrogation and reimbursement applies to all rights of recovery of the covered individual and the covered individual's dependents, parents, representative, guardian or trustee, regardless of whether the recovery fully compensates the covered individual for the loss. Acceptance of benefits from the Plan automatically assigns to the Plan any rights to recovery of duplicate payments. The Plan has a constructive trust and an equitable right to and lien with regard to any monies received by an employee or dependent and/or his or her attorney or representative from a third party to the extent of benefits as described above. You must forward any recovery to the Plan within ten (10) days of receipt or notify the Plan why you are unable to do so.

The Plan must be reimbursed in full up to the total amount of all benefits paid by the Plan in connection with the injury or illness from any recovery you receive from a third party, as well any first-party coverage, including, but not limited to, any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, school insurance or workers' compensation insurance, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party or first-party coverage (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse the Plan for benefits paid. In the event you receive an award for future medical expenses, the Plan will not pay any benefits until you demonstrate that the full award of future medical benefits has been used to treat the injury or illness. The Plan has the right of first reimbursement on a priority first-dollar basis out of any recovery obtained, even if you are not fully compensated (or "made whole") for your loss, and the Plan's claim has first priority over all other claims and rights.

Neither you nor your dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries for which benefits were paid by the Plan. The Trustees strongly recommend, however, that if you are injured as a result of the negligence or wrongful act of a third party, you should contact an attorney for advice and counsel. The Plan cannot and does not pay for the legal fees your attorney may charge.

The Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of the Plan's claim is subject to prior written approval by the Trustees in their sole discretion.

If you choose not to pursue the liability of a third party, the Plan will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with the Plan with respect to any attempt to recover Plan benefits payable to you or your eligible dependent related to an injury or illness caused by the act or omission of a third party.

Note that other provisions of the Plan may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g., Workers' Compensation cases, certain automobile accidents, etc.). Please review carefully the specific limitations and exclusions in this SPD.

COBRA CONTINUATION COVERAGE

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). This notice explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect your rights to obtain coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Plan Administrator: the Benefits Office, located at 10-27 46th Ave, Suite 300-2, Long Island City, NY 11101, Phone: (212) 356-8180, Fax: (212) 356-8181, benefits@cirbenefitfunds.org, is responsible for the administration of COBRA, and the organization to which you can direct questions about COBRA.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long?

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

"Qualified Beneficiary": Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan is a Qualified Beneficiary. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the

existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

Important Note: **Domestic Partners and child(ren) of Domestic Partners are NOT offered the ability to elect COBRA Continuation Coverage because Domestic Partners and child(ren) of Domestic Partners are not considered Qualified Beneficiaries.** Upon termination of coverage, a Domestic Partner and his/her child(ren) who are not Dependent(s) of the Employee will only be entitled to continue coverage under federal COBRA *if the Domestic Partner and his/her child(ren) were enrolled in the Plan the day before the Qualifying Event and the Employee elects to continue coverage for him/herself and elects to continue coverage for the Domestic Partner and his/her child(ren).*

"Qualifying Event:" Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan (e.g., employee continues working even though entitled to Medicare), then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary, and the maximum period of COBRA coverage based on that Qualifying Event:

	Maximum* Duration of COBRA for Qualified Beneficiaries[1]		
Qualifying Event Causing Health Care Coverage to End	**Employee**	**Spouse**	**Dependent Child(ren)**
Employee terminates employment (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in contributions (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	Up to 36 months	Up to 36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

* The maximum period of COBRA Continuation Coverage may be cut short, as explained in the section titled *Early Termination of COBRA Continuation Coverage*.

[1] When a covered employee's Qualifying Event occurs within the eighteen-month period after the Employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent child(ren) who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA Coverage for a maximum period that ends thirty-six (36) months after the date the Employee became eligible for Medicare.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either eighteen (18) months or thirty-six (36) months, depending on the Qualifying Event that occurred, and is measured from the date the Qualifying Event occurs. The eighteen (18) month period of COBRA Continuation Coverage may be extended for up to eleven (11) months under certain circumstances (see section on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section *Early Termination of COBRA Continuation Coverage* that appears later in this section.

Other Health Coverage Alternatives to COBRA

You, your spouse, and your dependent children may have other coverage options through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Marketplace Coverage

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for Deductibles, Coinsurance, and Copayments) right away, and you can see what your premium, Deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

COVERAGE THROUGH THE MARKETPLACE MAY COST LESS THAN COBRA CONTINUATION COVERAGE. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away.** The special enrollment right may also be available to you, your spouse, and dependent children if you continue COBRA for the maximum time available to you. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

You should keep in mind that if you sign up for COBRA Continuation Coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA Continuation Coverage early and switch to a Marketplace plan if you have another Qualifying Event such as marriage or birth of a child through something called a "special enrollment period." Be careful though - **if you terminate your COBRA Continuation Coverage**

early without another Qualifying Event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA Continuation Coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

NOTE: If you sign up for Marketplace coverage instead of COBRA Continuation Coverage, you cannot switch to COBRA Continuation Coverage once your election period ends.

Enrolling in another group health plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA Continuation Coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA Continuation Coverage.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight (8) month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA Continuation Coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA Continuation Coverage and later enroll in Medicare Part A or B before the COBRA Continuation Coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA Continuation Coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information about eligibility and enrollment, visit https://medicare.gov/medicare-and-you.

[1] See https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease.

Procedure for Notifying the Plan of a Qualifying Event

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event 60 days after the later of the date the Qualifying Event occurs or the date on which the Qualified Beneficiary loses (or would lose) coverage under HSBP as a result of the Qualifying Event.**

That written notice should be sent to the Benefits Office. The written notice can be sent via first class mail, hand-delivered or via email, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

The employee's own participating employer should notify the Benefits Office of an employee's death, termination of employment, reduction in hours, employer bankruptcy, or covered employee becoming entitled to Medicare. However, you or your family should also promptly notify the Benefits Office in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

NOTE: If such a notice is not received by the Benefits Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Notices Related to COBRA Continuation Coverage

The Benefits Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage within fourteen (14) days of when:

a) **your participating employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, you became entitled to Medicare, or the employer's bankruptcy, or

b) **you notify the Benefits Office** if a dependent child lost dependent status, you divorced or have become legally separated. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.

Under the law, you and/or your covered Dependent(s) will then have only 60 days after the later of the date of the election notice or the date on which you lose (or would lose) your coverage as a result of the Qualifying Event to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependent(s) do not elect COBRA coverage within 60 days after the later of the date of the election notice or the date on which you lose (or would lose) your coverage as a result of the Qualifying Event, you and/or they will have no group health coverage from this Plan after the date coverage ends as a result of the Qualifying Event.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you must complete the election form. This form must be received by the Benefits Office or postmarked on or before the date on the form, which is sixty (60) days after the later of the date of the election notice or the date on which you lose (or would lose) your coverage as a result of the Qualifying Event. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, the employee's spouse may elect coverage even if the employee does not. The spouse of an employee who is a Qualified Beneficiary may elect coverage on behalf of all other Qualified Beneficiaries.

NOTE: If you, your spouse and/or any of your covered dependents do not elect COBRA Continuation Coverage within sixty (60) days from the date of the Qualifying Event, you and/or they will have no group health coverage from the Plan after the date on which you lose coverage as a result of the Qualifying Event.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent by the Plan Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

The COBRA Continuation Coverage That Will Be Provided

COBRA Continuation Coverage entitles a person to the same health coverage that they had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section below, *Paying for COBRA Continuation Coverage* for information about how much COBRA Continuation Coverage will cost you and about grace periods for payments 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.

Note that the Plan's COBRA Continuation Coverage does not include Accidental Dismemberment, Ancillary Death, Hearing Aid, Life Insurance, Quality Improvement, Short-Term Disability or Long-Term Disability. COBRA Continuation Coverage is only applicable for health benefits.

Paying for COBRA Continuation Coverage

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families plus an additional 2%. If the eighteen (18) month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% to the cost of coverage applicable to the family unit (but only if the disabled person is covered) during the eleven (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, generally on an annual basis.

IMPORTANT

There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Benefits Office.

Grace Periods

The **initial payment** for the first month of COBRA Continuation Coverage is due to the Benefits Office **no later than forty-five (45) days** after the date that COBRA Continuation Coverage is elected (the date the election form is submitted). **If you do not submit payment at the time of election of coverage, your coverage will not be continued until payment is received and will terminate as scheduled due to the Qualifying Event.** When initial payment is received in full, coverage will be reinstated retroactively to the date that your coverage terminated or was scheduled to terminate. Note that if mailed, payment must be postmarked within forty-five (45) days from the date of election. **If payment is not received or postmarked on or before the last day of the forty-five (45) day grace period, you will no longer be eligible for coverage under the VHHSBP and will have no right to reinstate your benefits.**

Subsequent Monthly Payments

After the initial COBRA payment, **subsequent monthly premium payments** are due on or before the first day of each month of coverage to which it applies. There is **a thirty (30) day grace period** to make monthly periodic payments. If payment is not received on or before the first day of the month to which it applies, your coverage will be suspended as of the end of the period for which the last premium payment was remitted. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Payment by mail is considered made when it is postmarked. If you thereafter make a monthly periodic payment in full later than the first day of the coverage period to which it applies but before the end of the thirty (30) day grace period for the coverage period (the first 30 days of the month), your coverage will be retroactively reinstated (going back to the first day of the coverage period). If any periodic premium payment is not received or postmarked within the thirty (30) day grace period for the coverage period, you will no longer be eligible for coverage under the Plan, and you will have no right to reinstate your benefits.

Confirmation of Coverage before Election or First Payment of the Cost of COBRA Continuation Coverage

If, after you lose coverage due to a Qualifying Event, a health care provider requests confirmation of coverage and you, your spouse or dependent child(ren) are within the sixty (60) day COBRA election period but have not yet elected COBRA or, if you have elected COBRA Continuation Coverage but initial payment has not yet been made and the forty-five (45) day grace period is still in effect, the health care provider will be informed that you, your spouse and/or dependent

child(ren) do not currently have coverage but will have coverage retroactively to the date coverage was lost if coverage is elected and/or timely payment is made and that no claims will be paid until the amounts due have been received.

Confirmation of Coverage During a Thirty (30) Day Grace Period

If a health care provider requests confirmation of coverage and the periodic monthly payment for COBRA Continuation Coverage for that period has not been paid and the thirty (30) day grace period is still in effect, the health care provider will be informed that you, your spouse and/or dependent child(ren) do not currently have coverage but will have coverage retroactively to the first day of that month if timely payment is made and that no claims will be paid until the amounts due have been received.

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 do so within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. You must contact the Benefits Office within thirty-one (31) days to add a spouse or dependent.

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

If, during an eighteen (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, legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected dependent is extended to 36 months measured from the date of the initial qualifying event or the date you first became entitled to Medicare, if that is earlier.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Benefits Office in writing **within sixty (60) days** of the second Qualifying Event. The written notice can be sent via first class mail, be hand-delivered or sent via email, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

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. 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 eighteen (18) months (unless the Employee is entitled to an additional period of up to eleven (11) months of COBRA Continuation

Coverage on account of disability as described in the following section). 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 eighteen (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.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first sixty (60) days of an eighteen (18) month period of COBRA Continuation Coverage, the Social Security Administration ("SSA") makes a formal determination that you or a covered Spouse or Dependent Child are totally and permanently disabled within the meaning of Title II or Title XVI of the Social Security Act, the disabled person and any qualified beneficiaries in that family who so choose, may be entitled to keep the COBRA Continuation Coverage for up to twenty-nine (29) months (instead of eighteen (18) months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if the SSA determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and t**he disability lasts until at least the end of the eighteen (18) month period of COBRA Continuation Coverage.

Notifying the Plan: You or another family member must send a written notification to the Plan Administrator of the Social Security Administration determination **within sixty (60) days** of the later of 1) the date on which SSA issues the disability determination, 2) the date on which the Qualifying Event occurs, or 3) the date on which the Qualified Beneficiary loses (or would lose) coverage under VHHSBP as a result of the Qualifying Event. Failure to notify VHHSBP in a timely fashion may jeopardize an individual's right to extended coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Plan Administrator before the end of the 18-month COBRA Continuation period.

The cost of COBRA Continuation Coverage during the additional eleven (11) month period of COBRA Continuation Coverage may be up to 50% higher than the cost for coverage during the first eighteen (18) month period.

You must notify the Benefits Office within thirty (30) days of the date of determination by the SSA that you or a Qualified Beneficiary is no longer disabled.

Early Termination of COBRA Continuation Coverage

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

1. The date VHHSBP no longer provides group health coverage to any participants.

2. The date the premium payment amount due for COBRA coverage is not paid in full and on time.

3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA.

4. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: the Qualified Beneficiary must notify the Benefits Office as soon as possible once they become aware that they will become covered under another group health plan, by contacting the Benefits Office. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.

5. During an extension of the maximum COBRA coverage period to twenty-nine (29) months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the SSA to no longer be disabled.

6. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan).

7. The participating employer with respect to whom you obtained your coverage in the first place withdraws from the Plan. However, if the employer covers a classification of its employees under another group health plan, it must offer COBRA participants enrollment in the new plan for the duration of the eligible COBRA coverage period.

Notice of Early Termination of COBRA Continuation Coverage

The Plan Administrator will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

Brief Outline on How Certain Laws Interact with COBRA

FMLA and COBRA: taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur **after** the FMLA period expires, if the employee 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 participating employer that they are not

returning to employment prior to the expiration of the maximum FMLA twelve (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. If the alternative coverage is identical in cost and benefits but the coverage period is less than the COBRA maximum period of eighteen (18), twenty-nine (29), or thirty-six (36) months, the lesser time period can be credited toward covering the 18, 29, or 36-month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six (6) months while on a LOA, the six (6) months can be credited toward the COBRA maximum period.

If You Have Questions

If you have any questions about your COBRA rights, please contact the Benefits Office. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Keep Your Plan Informed of Changes in Your Circumstances

Remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Plan Administrator:

- within 31 days of a change in marital status (e.g., marry, divorce); or have a new dependent child; or
- 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
- within 60 days if a covered child ceases to be a "dependent child" as that term is defined by the Plan; or
- promptly if an individual has changed their address, becomes entitled to Medicare, or is no longer disabled.

NOTICE OF ELECTRONIC DISCLOSURE

The following guidelines pertain to the use of electronic notices by the Plan. When you consent to this agreement, either by checking off the electronic notification box on your enrollment form, or by completing a paper or electronic version of this agreement sent to you by the Benefits Office, you are consenting to the following:

VHHSBP may, at times, send Notices by e-mail to Plan participants who have consented to receive information electronically. These Notices include: information regarding Open Enrollment, plan amendments, your benefits, changes to your benefits, the Summary Plan Description (SPD), news and updates about your benefits, summary annual reports, COBRA notices, newsletters, and other employee benefit Notices. Notices may also be available on the internet at www.cirseiu.org/benefits. Completing this consent form does not guarantee that all communications will be sent electronically and the Plan may at times send communications via first class mail.

By submitting this consent form, you understand and agree to the following terms and conditions:

Privacy: By law, the Plan cannot use your information without your permission, except as described in our Notice of Privacy Practices located in this SPD.

Contact Information: You are responsible for ensuring the Plan has a current e-mail address for you at all times for electronic communications. If your e-mail address changes at any time, you must notify the Plan in writing or by sending an email to benefits@cirbenefitfunds.org. Any communication sent by the Plan to the most recent e-mail address on file will be deemed delivered to you.

Cancellation: You can withdraw your consent at any time by contacting the Plan in writing or by sending an email to benefits@cirbenefitfunds.org.

Flexibility: You have the right to request a paper copy of any electronic notice sent to you, free of charge.

Hardware/Software Requirements: You must ensure that you are able to receive information electronically and retain it. You must have a computer system with an Internet Web browser capable of 128-bit encryption, and Adobe Acrobat Reader. You must have a printer capable of printing any disclosure made available on our website and/or emailed to you, or have the ability to electronically save such documents.

Risks: The Plan can't promise security and/or confidentiality when e-mailing. Although unlikely, it is possible an e-mail may be incorrectly shared or intercepted by someone other than the party to whom it was addressed. By completing this consent form, you understand these risks, and cannot hold the Plan responsible if such an event occurs.

Consent: I consent to the electronic disclosure by the Plan of all employee benefit Notices. I acknowledge that I have read the "Notice of Electronic Disclosure" and understand that I am entitled to withdraw my consent at any time with written notice to the Plan. I understand the risks associated with the use of electronic communications and assume all risks and responsibilities. I

understand that I can receive a paper copy of all employee benefit Notices upon request at no charge. I also confirm that I have the ability and software to access the internet, and to view the documents.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Voluntary Hospitals House Staff Benefits Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related Illness/Injury, sick leave, Family and Medical leave (FMLA), or Death Benefits.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, distributed to you upon enrollment in the Plan and is also available from the Benefits Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees), will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment, health care 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.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

1. **The Plan's Use and Disclosure of PHI**: The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    a. **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your Health Care Providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

b. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

1) Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, Plan maximums, Copayments as determined for an individual's claim), and establishing employee contributions for coverage;

2) Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

3) Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

c. **Health Care Operations** includes, but is not limited to:

1) Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

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) Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

4) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

5) Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

6) Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

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

3. 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:

   a. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
   b. Ensure that any agents, including their subcontractors, 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. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
   c. Not use or disclose the information for employment-related actions and decisions;
   d. 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 or disclosed in the Plan's Notice of Privacy Practices);
   e. 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;
   f. Make PHI available to the individual in accordance with the access requirements of HIPAA;
   g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
   h. Make available the information required to provide an accounting of PHI disclosures;
   i. 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 the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA; and

j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor 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 of the PHI infeasible;

k. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you

4. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

   a. The Plan Administrator,

   b. Staff designated by the Plan Administrator

   c. Business Associates under contract to the Plan including but not limited to the medical claims administrators, preferred provider organization network, member assistance program, prescription drug program, dental claims administrator, vision claims administrator.

5. The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

6. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor will:

   a. 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;

   b. Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

   c. 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

   d. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

7. Hybrid Entity: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, dental plan options, vision plan options, and COBRA administration.

Availability of a HIPAA Privacy Notice for Your Group Health Plan

If you would like to see (or obtain a copy of) the plan's HIPAA Notice of Privacy Practices, please call the Benefits Office at (212) 356-8180. The Notice describes how the plan uses and discloses protected health information for the Plan's Hospital, Medical, Prescription Drug, Vision benefits, and COBRA Administration. It also discusses important federal rights that you have with respect to your protected health information. This Notice does not apply to the insured Dental benefits provided through a contract with Guardian Life Insurance. You should have received a HIPAA Privacy Notice directly from them outlining their privacy practices. You may request a copy of Guardian Life Insurance's HIPAA Privacy Notice that pertains to the insured dental benefits by contacting them directly at:

Guardian
P.O. Box 4391
Woodland Hills, CA 91367
(888) 600-1600

ERISA STATEMENT OF RIGHTS UNDER THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and

Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

Continue Group Health Plan Coverage

You also have the right to:

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (you or your dependents may have to pay for such coverage; review this SPD and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights).

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The New York office is located at:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
33 Whitehall Street, Suite 1200
New York, NY 10004
(212) 607-8600

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by: calling (866) 444-3272 or visiting www.dol.gov/ebsa.