Bricklayers & Allied Craftworkers
Local 8 NY Welfare Plan

Group Health, Dental and Vision Insurance
Summary Plan Description

January 1, 2019

Important Notice

You should carefully read this summary plan description as it contains important information about the group health plan provided to you, including the plan's eligibility requirements, claims procedures, and your rights & responsibilities.

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INTRODUCTION

Purpose of Summary Plan Description

This summary plan description (SPD) summarizes the benefits available under the Bricklayers & Allied Craftworkers Local 8 NY Welfare Fund's group Welfare Plan (the "Plan") and explains the Plan's eligibility requirements, claims procedures, and your rights and responsibilities. It does not contain all Plan details. In determining your specific benefits, the full provisions of the formal plan documents, as they exist now or as they may exist in the future, always govern.

The Board of Trustees of the Bricklayers & Allied Craftworkers, Local 8 NY Welfare Fund (the "Fund") sponsors the Plan for the exclusive benefit of its eligible participants and their eligible family members. This document summarizes important information about the Plan. The Plan provides health and welfare benefits through the following component benefit programs:

- **Group Medical Insurance;**
- **Group Dental and Vision Insurance;**
- **Retiree Medical Insurance;**
- **Health Reimbursement Account (HRA);**
- **Medicare Advantage Plan; and a**
- **Life Insurance Program.**

The Group Contract of the insurance company whose product is then being used will control in defining the specific benefits to which you and your covered Dependents are entitled including any deductibles, co-payments, lifetime or annual caps, network providers, and any other conditions or limitations on benefits. You will be provided with a summary of these benefits. An insurance benefit booklet or certificate of coverage, which provides a detailed description of your benefits is available directly from the insurance company and you may obtain a copy from the carrier's web site or, free of charge, from the Fund Office.

You must comply with the terms of the applicable Insurance Benefit Booklet to obtain any Plan benefits insured by that insurance company. You will not be eligible for benefits for any period in which you are not in compliance with the terms of the insurance benefit booklet even if you later become compliant.

General Fund Information

The name of the Fund is the Bricklayers & Allied Craftworkers, Local 8 NY Welfare Fund.

Except as otherwise provided, the provisions of the Plan that are described in this booklet became effective on January 1, 2019.

The Fund's financial records are maintained on a twelve-month period of time. This is known as the Fiscal Plan Year. The Fiscal Plan Year is the twelve-month period beginning on May 1 and ending the following April 30.

Plan Administrator

The Plan is sponsored by the Board of Trustees of the Bricklayers & Allied Craftworkers, Local 8 NY Welfare Fund. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund.

The employer identification number of the Plan Sponsor is 16-6058900. The Trustees have assigned plan number 501 to the Fund.

The following individuals currently comprise the Board of Trustees:

Employer Trustees	**Union Trustees**
Brett Sherman	Tim Hayes
Bradley Walters	Brian Edwards
	Duane Vorhis

Responsibility for administration of health and hospital, dental and vision insurance claims has been delegated to the insurance company or health maintenance organization providing those benefits. Responsibility for administration of the HRA benefit has been delegated to a third-party claims administrator. The Board has retained responsibility for the administration of the life insurance benefit.

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals or entities, including any insurance company, to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Fund or the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

Fund Administrator Information

The Trustees have delegated certain day-to-day administrative duties to the Fund Administrator. The name and address of the current Fund Administrator is:

Ashley Tilebein
Fund Administrator
BAC Local 8 NY
701 West State St.
Ithaca, NY 14850
P: 607.272.3853
F: 607.272.2966

The Fund Administrator also keeps the records for the Fund. The Board of Trustees has authorized the Fund Administrator to respond in writing to any questions you may have about the Fund. As a courtesy, the Fund Administrator may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot

be relied upon in a dispute concerning your benefits. If you have an important question, you should contact the Fund Administrator for a written response. Keep in mind, however, that the official Plan documents (which include this booklet) govern at all times even if they are inconsistent with advice you receive.

Service of Legal Process

The name and address of the Fund's agent for service of legal process is:

Bricklayers and Allied Craftworkers, Local 8 NY Welfare Fund
701 West State St.
Ithaca, NY 14850

Legal process may be served on the Plan Administrator or any individual Trustee.

Type of Plan

The Plan is a welfare benefit plan providing health, hospitalization, dental, vision, health care reimbursement, and life insurance benefits. The health, hospitalization, dental and vision benefits are insured through insurers or health maintenance organizations. Other benefits are provided on a self-insured basis.

The Plan is maintained pursuant to one or more collective bargaining agreements. The collective bargaining agreements contain a clause providing for contribution to the Fund. A copy of any such agreement may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries. A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination during normal business hours. Participants and beneficiaries may also receive from the Plan's Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

Definitions

Throughout this SPD, the following terms and definitions apply:

The term **"Collective Bargaining Agreement"** will mean any agreement between the Union and an Employer that requires the payment of periodic Contributions to the Fund or other written participation or other agreement acceptable to the Trustees that requires the payment of periodic Contributions to the Fund.

The term **"Covered Employment"** will mean employment of a type covered by a Collective Bargaining Agreement and requiring contributions on your behalf to the Fund.

The term **"Employee"** will mean any person employed by an Employer and covered by a Collective Bargaining Agreement.

The term **"Employer"** will mean (i) any one of the employer members of an employer association that enters into a Collective Bargaining Agreement with the Union; (ii) an independent signatory to a Collective Bargaining Agreement that is acceptable to the Board of

Trustees; (iii) the Fund itself; (iv) the Union; and (v) any signatory to a participation or other agreement requiring payment of periodic Contributions to the Fund by such person or entity that is acceptable to the Board of Trustees.

Bricklayers & Allied Craftworkers, Local 8 NY Welfare Fund is referred to as **"the Fund."**

The employer's group health insurance plan may be referred to as the **"group health plan"** or **"the plan."**

The insurance company insuring benefits under the Plan may be referred to as **"the carrier."**

A **"subscriber"** is the Employee who meets the Plan's applicable eligibility requirements, is enrolled in the group health plan, and has paid the required premiums.

"Eligibility Year" - The Eligibility Year to become an insured Plan participant is October 1st- September 30th.

"Benefit Year"- The period of time in which you are medically covered by the Plan is Jan 1-Dec 31.

"Totally Disabled" – for Employee coverage, means disability to the extent that a Covered Employee is unable to perform any of the usual and customary duties of his occupation; and for Dependent coverage, means disability to the extent that the Dependent is unable to perform the usual and customary duties or activities of a person in good health and of the same age and sex. After 6 months, the Plan may require a determination that the Employee or Dependent is disabled under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act.

A **"deductible"** is a fixed dollar amount that you must pay for covered services each plan year before the carrier begins to pay benefits for certain covered services. The deductible is paid directly to the provider. Once the individual or family deductible (based on the coverage you have elected) is met in a plan year, no further deductible is required for the remainder of the plan year. Preventive care services, such as cleanings, are generally covered in full and are not subject to the deductible. Refer to the insurance benefit booklet for additional information.

You may be required to pay a charge, in the form of either a percentage **(i.e., "coinsurance")** or a fixed dollar amount **(i.e., "copayment")** for the cost of certain covered services. Coinsurance rates may vary depending on whether the service is received from a network or non-network provider. Likewise, coinsurance rates may vary for different types of services. Coinsurance and copayments are paid directly to the provider and are usually due at the time the service is received

Disclaimer

This Plan is offered to Employees, their spouses, and dependents on a voluntary basis. The Trustees reserve the right to amend or terminate the plan at any time and for any reason.
Every effort has been made to ensure that the information presented in this document is accurate and up-to-date. However, in the event there is a conflict or inconsistency between the information presented in this SPD and the insurance contract, or certificate of coverage issued by the carrier, the terms set forth by the insurance contract, or certificate of coverage will

prevail. For complete details regarding covered benefits and exclusions, refer to these documents.

The carrier has the exclusive authority to interpret the benefits, terms, conditions, limitations, and exclusions set forth in the medical or dental and vision policies, as applicable.

No wording contained in this SPD or your participation in the plan should be interpreted as a contract or guarantee of employment with your employer.

Summary Plan Description Revisions

When there are revisions to the plan or the information presented in this SPD, you will receive an updated copy of the SPD or the revisions will be attached to this document and noted as **"Summary of Material Modification" or "SMM."** You will receive the updated SPD or SMM within 210 days after the end of the plan year in which the change(s) to the plan become effective. If the change is a material reduction in covered services or benefits, the updated SPD or SMM will be provided not later than 60 days after the reduction is adopted.

Obtaining a Copy of the Summary Plan Description

You have a right to examine or receive a free copy of this SPD, any SMMs, and the plan document at any time by contacting the Fund Administrator who will comply with your request within 30 days.

Requesting the SPD in another Language

The plan's SPD is provided in English. If you have difficulty understanding any part of this document or if you would like a copy of the SPD in another language, contact your employer.

Member Service Department

If you have any questions about your benefits or would like information regarding any aspect of the plan, including how to file a grievance or request a network/provider directory, call the Member Service Department at the telephone number listed with the corresponding carrier.

Membership Insurance Cards

The carrier will provide the subscriber with a membership insurance card at the time of enrollment in the plan. The subscriber may also receive a new card at the beginning of each plan year. Each member, if applicable, may also receive a duplicate ID card. **You should present your insurance card to providers at the time service is received to help ensure proper handling of your claim.** You may request a new insurance card by contacting Member Service or going to the carrier's website.

Benefits Documents

The carrier may provide you with benefits booklets and a network/provider directory at the time of enrollment in the plan. You may also contact Member Service or go to the carrier's website to request these or any of the following documents from the Fund Office at no charge:

- Benefits Summary
- Certificate of Coverage
- Insurance Contract

Change in Address

Periodically, the carrier and the Fund Office will mail benefits-related information to your home address. **You should therefore notify the carrier promptly if your address changes by calling Member Service or making the change on-line at the carrier's website and contacting the Fund Office.**

Summary Plan Description
Supplement To Certificates

DETAILS OF GROUP HEALTH INSURANCE CARRIER

(Active Participants and Under 65 retiree Coverage)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan
Insurance Plan Name:	Excellus Blue PPO Signature Deductible 3
Carrier: **Excellus BlueCross BlueShield** **165 Court Street** **Rochester, NY 14647**	**Claims Department:** **Excellus BlueCross BlueShield** **P.O. Box 22999** **Rochester, NY 14692**
Web Site: www.excellusbcbs.com	
Member Service Telephone #: 1.800.499.1275	
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 (17 NY) Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Group Number:	001126900001
Type of Plan:	Fully-insured plan providing medical benefits through a contract with the carrier.
Administration of Plan:	As the plan administrator, the Trustees contract with the carrier to provide administrative services, including claims processing, payment of benefits, and contracting with providers for direct payments, where applicable.
Funding of Plan:	The carrier assumes financial responsibility for members' medical claims and for administrative costs. There are no plan assets in the event the plan is terminated.
Plan Year:	January 1st - December 31st

DETAILS OF HEALTH REIMBURSEMENT BENEFITS

(Active Participants and Under 65 Retiree Coverage)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan
Carrier: **Lifetime Benefits Solutions**	**Claims Department:** **Lifetime Benefit Solutions** **P.O. Box 22999** **Rochester, NY 14692**
Web Site: www.www.lifetimebenefitsolutions.com	
Member Service Telephone #: (585) 273-7100	
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 (17 NY) Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Type of Plan:	Self-insured plan providing medical benefits
Administration of Plan:	As the plan administrator the Trustees contract with a claims administrator to provide administrative services, including claims processing, payment of benefits, and contracting with providers for direct payments, where applicable.
Funding of Plan:	Benefits are paid from the general assets of the Fund
Plan Year:	January 1st - December 31st

DETAILS OF GROUP DENTAL INSURANCE CARRIER

(Active Participant Coverage)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan
Insurance Plan Name:	Guardian- DentalGuard Preferred Network
Guardian Group Benefits Group Dental Claims PO Box 981572 El Paso, TX 79998-1572 Web site: www.GuardianAnytime.com	
Web Site: www.guardiananytime.com	
Main Telephone #: 1-800-541-7846	
Member Service Telephone #:1-800-541-7846	
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 (17 NY) Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Plan Number:	G-00543395
Group Number:	00543396
Type of Plan:	Fully-insured plan providing dental benefits through a contract with the carrier.
Administration of Plan:	As the plan administrator, your employer contracts with the carrier to provide administrative services, including claims processing, payment of benefits, and contracting with providers for direct payments, where applicable.
Funding of Plan:	The carrier assumes financial responsibility for members' dental claims and for administrative costs. There are no plan assets in the event the plan is terminated.
Plan Year:	January 1st-December 31st

DETAILS OF GROUP VISION INSURANCE CARRIER

(Active Participant Coverage)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan
Insurance Plan Name:	Davis Vision Full Feature- Premier B
Guardian Group Benefits 7 Hanover Square New York, NY 10004	
Web Site: www.guardiananytime.com	
Providers Telephone #: 1-800-773-2847	
Member Service Telephone #:1-877-393-7368	
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 NY Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Plan Number:	G-00543395
Group Number:	00543396
Type of Plan:	Fully-insured plan providing vision benefits through a contract with the carrier.
Administration of Plan:	As the plan administrator, your employer contracts with the carrier to provide administrative services, including claims processing, payment of benefits, and contracting with providers for direct payments, where applicable.
Funding of Plan:	The carrier assumes financial responsibility for members' vision claims and for administrative costs. There are no plan assets in the event the plan is terminated.
Plan Year:	January 1st – December 31st

DETAILS OF GROUP LIFE INSURANCE

(All Eligible Participants)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan Group Life Insurance Plan
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 NY Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Type of Plan:	Paid directly by the fund
Administration of Plan:	As the plan administrator, to the Trustees are responsible to provide administrative services, including claims processing and the payment of benefits.
Funding of Plan:	. Benefits are provided on a self-insured basis and are paid from the general assets of the Fund.
Plan Year:	January 1st- December 31st

DETAILS OF GROUP MEDICARE PART C PLAN

(Medicare Eligible Participants)

Name of Plan:	Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan
Insurance Plan Name:	MVP USA Care PPO or MVP GoldAnywhere PPO
Carrier: **MVP Health Care** **P.O. Box 2207** **Schenectady, NY 12301**	**Claims Department:** **Claims Submission** **MVP Health Care** **P.O. Box 2207** **Schenectady, NY 12301**
Web Site: www.mvphealthcare.com	
Member Service Telephone #: 1-800-665-7924	
Plan Sponsor and Plan Administrator Name and Address:	Board of Trustees, BAC Local 8 NY Fringe Benefit Funds 701 West State St. Ithaca, NY 14850 P: 607.272.3853 *All administrative and legal notices should be directed to Ashley Tilebein, Fund Administrator at the above address.
Group Number:	413512_0002 or 413512_0003
Type of Plan:	Part C Medicare Advantage plan providing medical benefits through a contract with the carrier.
Administration of Plan:	As the plan administrator, the Trustees contract with the carrier to provide administrative services, including claims processing, payment of benefits, and contracting with providers for direct payments, where applicable.
Funding of Plan:	The carrier assumes financial responsibility for members' medical claims and for administrative costs. There are no plan assets in the event the plan is terminated.
Plan Year:	January 1st - December 31st

ENROLLMENT, ELIGIBILITY, AND RETIREE OPTIONS

Eligibility for Coverage

Participant Eligibility – An active Employee must earn at least **1000 hours** in Covered Employment **in an eligibility period (Oct 1st-Sep 30th)** to be eligible for benefits the following Benefit Year. Once coverage begins, in the event he/she fails to earn the 1000 hours in a future Eligibility Year, provided he/she is working, or eligible for work, in an area covered by the Collective Bargaining Agreement, he/she will begin the right to self-pay the difference if he/she has worked at least 300 hours in an Eligibility Year.

The amount of hours required for eligibility does not cover the actual cost of benefits to the Plan. Therefore all hours accumulated over 1000 hours remain in the Fund to provide these benefits. Additional hours worked cannot be rolled over to a future Eligibility Year.

This Plan does not discriminate for purposes of eligibility or premiums based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, and disability. However, the foregoing does not require the Plan to provide specific benefits or prevent it from applying limitations or restrictions on the amount, level, extent or nature of benefits or coverage for similarly-situated participants.

Term of Eligibility – An Employee will continue to be eligible for coverage provided he/she continues to work 1000 hours per Eligibility Year, or made the required self-payments if he/she has worked at least 300 hours in the prior Eligibility Year. An Employee's eligibility will terminate as of Dec 31st when the Employee has not worked 1000 hours, or has failed to make the required self-payments if he/she has worked at least 300 hours in the prior Eligibility Year. (Refer to COBRA benefits for information on potential extension of benefits if you worked less than 300 hours).

Self-Pay Contributions – The Board of Trustees is authorized to determine the number of hours for which individual Employees may make self-contributions to the Fund to continue to be eligible for benefits. Once eligibility requirements have been met in a prior Eligibility Year, an active Employee who has worked **at least 300 hours is permitted to pay the difference between 300 hours and 1000 hours at the current hourly contribution rate.** The Board of Trustees allows the Employee to make the payment in 1, 2, 4 or 12 installments, whichever fits your financial situation.

If an Employee fails to make an installment payment, his/her coverage will be terminated and the Employee will be required to re-qualify with 1000 hours worked in a future Eligibility Year.

New Employee Self-Pay Option - If a New Employee has worked less than 1000 hours in Covered Employment in an Eligibility Year, but has worked at least **500 hours in an Eligibility Year**, the Employee is eligible to purchase coverage at the current hourly contribution rate. The

Board of Trustees allows the Employee to make the payment in 1, 2, 4 or 12 installments, whichever fits your financial situation.

If an Employee fails to make an installment payment, his/her coverage will be terminated and the Employee will be required to re-qualify with 1000 hours worked in a future Eligibility Year. This option is only available to new Employees. Any Employee that has had prior coverage at any time will not be eligible.

An Employee's eligibility to participate in the Plan requires continued employment with the employer and is subject to the terms and conditions of the plan document, insurance contract, and certificate of coverage.

Retiree Eligibility- Retired members and their spouses may be eligible for Retiree Coverage by meeting the eligibility requirements. **A retired member must have been enrolled in the plan under normal active participant status for 10 consecutive years prior to retirement**. This can not include any COBRA coverage.

Medicare Eligible Participants and spouses are required to pay a monthly premium rate equal to ½ of the monthly premium charged by the current Medicare Part C Plan to the Fund Office.

Retiree Participants who return to work and achieve 1,000 hours or more in an Eligibility Year will be **entitled to** hospital, major medical, and prescription drug coverage through Excellus BCBS and Dental/Optical **benefits, as provided to active participants for the next Benefit Year, without any out-of-pocket premium cost.**

Retiree Participants who meet the retiree eligibility rules and who return to work and achieve less than 1,000 hours in an Eligibility Year are eligible for all of the same **hospital, major medical, and prescription drug benefits** as offered to active participants for the next Benefit Year, provided the **Retiree Participant pays the full monthly premium charged by the carrier for coverage. However, there will be no Dental/Optical benefits offered.**

Eligible Dependents

An eligible Employee may enroll his or her eligible dependents in the Plan. The following individuals are considered an Employee's eligible dependents:

- Your legal spouse (includes same or opposite sex spouse), unless you are divorced or the marriage has been annulled;

- A natural, step, legally adopted, or foster son or daughter. Coverage continues until the end of the month in which the child turns age 26. Note: The child does not need to be a full-time student, unmarried, financially dependent on the employee, claimed as a dependent on the employee's tax return, or a resident of the employee's household;

- Domestic partner; ask the Fund Office for the proof of domestic partnership packet

- Unmarried children of any age if:

- They are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined in applicable state law or because of physical handicap; and
- They became incapacitated before reaching the age at which coverage as a dependent would otherwise have been terminated under the group plan.

Refer to the insurance contract or certificate of coverage for further information regarding dependent eligibility and the definition of “child,” “spouse” and “domestic partner.”

The insurance carrier reserves the right to request proof of an individual’s dependent status.

Young Adult Coverage to Age 29

In accordance with New York State insurance regulation, young adults who reach age 26 and are no longer eligible to remain a dependent under their parents’ health insurance coverage may independently purchase coverage through the plan until the age of 29. Young adults can also enroll in the plan when they newly meet the eligibility criteria (e.g., if they are no longer eligible for health insurance coverage through their employer).

In order for a young adult to be eligible for this coverage, he or she must meet the following criteria:

- be 29 years of age or younger,
- be unmarried;
- not be covered under the health insurance plan offered through his or her employer or Medicare;
- live, work, or reside in New York State or the plan's service area; and
- have a parent who is covered under the plan as an employee (this can include continuation coverage under COBRA or New York State insurance regulation).

The young adult does not have to live with the parent or be financially dependent on the parent.

Additional information is provided in the insurance contract and certificate of coverage. This option is not available for Dental/Optical coverage.

Notification of Any Event Affecting Your Eligibility

You are responsible for notifying the Fund Administrator of any event that affects your eligibility for coverage under the plan, including but not limited to:

- Divorce or annulment;
- Death of a spouse or dependent;
- Medicare eligibility;
- Coverage under another group health plan;
- Dependent marrying or reaching the age at which eligibility terminates; or
- Change or termination of a medical support order.
- End of a domestic partnership (refer to the insurance contract and certificate of coverage for the definition of a “domestic partner”)

Enrolling in the Health Insurance Plan

During the annual **open enrollment period of December 1st through December 30th**, benefits-eligible Employees may elect or waive coverage in the Plan as well as add or drop coverage for eligible dependents. At this time, any plan or premium changes for the upcoming plan year are communicated to employees

In order to enroll in the Plan, or continue enrollment, Employees must submit a completed enrollment form and any required documents to the Fund Office at least 5 days prior to the eligibility effective date of January 1st.

Election Changes During the Plan Year

During the Plan Year, an Employee generally cannot change his or her election (e.g., switch from single to family coverage or vice versa) or cancel coverage **unless** the Employee experiences one of the following changes in status:

- Addition or loss of a spouse through marriage, death, divorce, annulment, or legal separation;
- Addition of a dependent through birth or adoption;
- Gaining a step-child or becoming legal guardian of a child;
- A dependent child has a change in, or loss of, dependent status under the plan; or
- Receiving a qualified medical child support order (MCSO).

In accordance with IRS rules, if an employee experiences one of the above changes in status, any change to his or her benefit election for the remainder of the plan year must be on account of and consistent with this change in status.

To add or drop a dependent to an employee's coverage, the required form(s) and acceptable proof of the change in status must be submitted to the employer within 30 days of the change in status. If you fail to enroll or cancel your own or a dependent's coverage within the required time frame, you will normally have to wait until the next open enrollment period to make any benefit election changes.

Refer to the insurance contract or certificate of coverage for additional information regarding election changes.

Special Enrollment Rights

If you decline coverage in the group health insurance plan for yourself and/or your covered dependents **at the time of initial eligibility** or during subsequent open enrollment periods **because you had other health insurance coverage**, **you and your covered dependents may be allowed to enroll in your employer's plan during the plan year if eligibility for the other coverage is lost due to:**

- Your termination of employment or reduction in the number of hours worked;

- Termination of the other group health plan or contract (including COBRA or New York State health insurance continuation coverage);
- Your death;
- Your legal separation, divorce, or annulment;
- Marriage to, or divorce from, a same-sex spouse;
- Your domestic partner no longer meeting the definition of domestic partner under the plan;
- Your dependent no longer meets the definition of dependent under the plan due to age, work, marital, or school status;
- You or your dependent(s) lose eligibility under the Children's Health Insurance Program (CHIP) or Medicaid and you otherwise meet the group health plan's eligibility requirements;
- The employer or other group ceased its premium contribution for the plan or contract; or
- A change in residence or work location which has affected your benefit coverage (e.g., you no longer reside or work in the plan's service area).

To request special enrollment under the plan, a completed enrollment form and acceptable proof of the change in status must be submitted to the employer within 30 days after the event or loss of other coverage. If you lose your eligibility for CHIP or Medicaid, you have 60 days after the loss of eligibility to enroll in the group health plan. If you fail to enroll within the required time frame, you will have to wait until the next open enrollment period to elect coverage.

Refer to the insurance contract or certificate of coverage for additional information regarding election changes.

There are no special enrollment rights for dental or vision coverage.

When Coverage Begins

Annual open enrollment coverage is effective the 1st of the month following the end of open enrollment. **(January 1st)**

Enrollment due to changes in employee or dependent status or as a result of special circumstances is outlined in your contract.

Members must satisfy all enrollment requirements prior to the date of coverage.

Levels of Coverage

You may select one of the following levels of coverage at the time of enrollment in the plan:

- Individual
- Family

The Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you are eligible for the Fund's group health coverage but are unable to afford the premiums, participating states, such as New York, offer premium assistance programs that can help pay for coverage under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Under CHIPRA, New York use funds from its Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a participating state such as New York, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, call 1-877-KIDS NOW, or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the participating state if it has a program that could help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP and you meet the plan's eligibility requirements, the company's group health plan is required to permit you and your dependents to enroll in the plan. You must request coverage in the plan within 60 days of being determined eligible for premium assistance.

Termination of Coverage

Coverage under the plan will terminate at 12:00 midnight on the last day of the month.

- You fail to make your required contribution toward the premium payments;
- You are no longer eligible to participate in the plan because your work hours are reduced or you otherwise do not meet the plan's eligibility requirements;
- The date the plan itself is terminated;
- Death of employee (for a dependent, the day of the employee's death);
- For a dependent child, when the dependent ceases to meet the plan's eligibility requirements;
- For your domestic partner, the date your domestic partnership ends; or
- For your spouse, the date of a divorce, legal separation, or annulment.

This list is not all-inclusive. When coverage under the plan is terminated, you and/or your dependents may be eligible for continuation coverage as described later in this document. Refer to the insurance contract or certificate of coverage for additional information regarding termination of coverage.

DESCRIPTION OF THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Type of Health Insurance Plan

The Fund's group health insurance plan is a High Deductible Health Plan (HDHP) through Excellus BlueCross BlueShield, combined with a Health Reimbursement Account (HRA), administered by Lifetime Benefit Solutions. A HDHP offers low insurance premiums with a high annual deductible that must generally be met before you receive benefits for covered services. A limited number of benefits, including preventive services, are not subject to the deductible. Refer to the certificate of coverage for a complete description of the plan's coverage.

At the time of enrollment, you will receive a benefit summary. To receive maximum benefits, you must comply with the terms and conditions of the insurance contract or certificate of coverage.

Health Reimbursement Account

A Health Reimbursement Account or Health Reimbursement Arrangement *(HRA)* is an Internal Revenue Service (IRS) sanctioned employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums. Using a Health Reimbursement Account yields tax advantages to offset health care costs for both employees as well as employers.

Each covered individual must meet an individual deductible of $150 per plan year before they are eligible for HRA reimbursements. The HRA then reimburses the member 80% of the medical carrier's remaining in network deductible expenses. The HRA only reimburses for claims submitted to your group medical insurance.

Paying for Qualified Expenses

When you seek care from a health care provider, the Medical Insurance Carrier will provide you with an explanation of benefits (EOB) detailing the amount, if any, you are responsible for paying. If you have a Health Savings Account, or HSA, through your bank, you may use your HSA debit card or checking account to pay for any qualified medical expenses that are not covered under the plan.

HEALTH PLAN PAYMENTS AND COVERAGES FOR GROUP HEALTH PLAN (EXCELLUS BLUECROSS BLUESHIELD)

Prescription Drug Coverage

The plan offers a four-tier system of cost-sharing for prescription drugs. You may get your prescriptions filled at any participating pharmacy.

Preventive Care Services

Certain preventive care services (e.g., annual physical, routine immunizations) are covered in full when care is received from a participating/in-network provider. However, cost sharing may apply to services received during the same visit as the preventive care service. Refer to the certificate of coverage for a complete list of preventive care services that are covered in full under the plan.

Annual and Lifetime Limits

There are no annual or lifetime limits as to what the plan will pay per member for "essential benefits" that are covered under the plan.

Out-of-Pocket Maximum

There is an out-of-pocket maximum that each member must pay out-of-pocket (e.g., deductible, coinsurance, copayments) for covered benefits per plan year. Once this dollar amount is reached, the Medical Insurance Carrier pays your covered benefits in full for the remainder of the plan year. Each member is responsible for his or her own out-of-pocket maximum.

Pre-Certification/Prior Authorization

In order for certain medical benefits to be covered under the plan, your primary care physician must obtain prior authorization or pre-certification from the insurance carrier. Your primary care physician may also need to obtain authorization before referring you to a specialist in the network. Referrals are not required before seeking care from a participating OB/GYN provider.

The carrier will review the reasons for the planned treatment and make a determination as to whether benefits are available for the service requested. The carrier will notify both you and your provider, in writing, of its determination. If the determination is a denial, the notification will include the reason for the denial.

You should contact the carrier's Member Services to inquire as to whether a service is covered under the plan or if pre-certification is required. Failure to obtain a referral or pre-certification for non-emergency care may reduce or eliminate coverage for the services received.

Coverage When Traveling Outside the Service Area

Emergency coverage is normally available when traveling outside of the regional service area from a national network of doctors when it is coordinated with your carrier. You should read the emergency care section in your benefits booklets and the certificate of coverage before you travel to familiarize yourself with the coverage available.

Emergency Care

The plan covers care received at either an emergency room or urgent care facility if your illness or condition is considered an emergency medical condition as defined in the certificate of coverage. Prior approval from your PCP or the plan is not required. Follow up care or routine care provided in a hospital emergency department is not covered.

Emergency care benefits apply when you are outside the service area. Prior approval is not required before seeking care for an emergency medical condition at an out-of-network emergency room or urgent care facility.

DESCRIPTION OF DENTAL AND VISION

Plan payments and coverages

At the time of enrollment, you will receive a benefit summary. To receive maximum benefits, you must comply with the terms and conditions of the insurance contract or certificate of coverage. Refer to the certificate of coverage for a complete description of the plan's coverage, which you may obtain at no charge from the carrier or the Fund Office.

Dental

Your Dental Benefits are provided through **Guardian Group Benefits' network: Dental Guard. Claims will be submitted directly to the insurance carrier by your provider.** You will be responsible for any balances after consideration by your dental insurance. It is important to note that out of network coverage is based on a percentage of the in network fee schedule.

Vision

Your Vision Benefits are provided through **Guardian Group Benefits' network: Davis/Full Feature- Premier B. Claims will be submitted directly to the insurance carrier by your provider.** You will be responsible for any balances after consideration by your vision insurance.

DESCRIPTION OF LIFE INSURANCE BENEFIT

Life Insurance benefits are provided through The Bricklayers Health Fund.

The Death benefit is payable on covered Employees only. The Death benefit does not cover any Dependent. If you die from any cause while you are insured, the proceeds will be paid to your beneficiary. If you do not leave a named beneficiary, such benefit will be paid to the estate of the Employee. **The current death benefit is $6,000.00.**

Beneficiary:
You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form and mailing it to the Fund Office.

Total and Permanent Disability:
If you become Totally Disabled before age 60, while covered under the Plan, your life insurance coverage will continue at no cost to you. Such **coverage shall continue only** as long as you are unable to engage in any gainful occupation, and **as long as you continue to be covered under the Ithaca Bricklayers Health Plan**. Verification of your disability must be submitted to the Fund Office. This protection will terminate if you fail to be covered under the health plan, cease to be Totally Disabled, if you fail to furnish proof of continuing total disability or fail to submit to medical examinations as required in the discretion of the Board of Trustees.

Retiree Life Insurance:
The Fund will continue to provide life insurance coverage for any Employee who retires while covered by the Plan, and continues to remain covered by the Plan.

MEDICARE PART C PLAN, DESCRIPTION OF COVERAGES

Medicare at age 65:

You and your spouse, if applicable, become eligible for Medicare at age 65. To remain covered under this plan, you and your spouse must elect Medicare part A and B when you turn 65, at which time you should complete the application for MVP Medicare Part C enrollment. **Contact the Fund Administrator for your MVP enrollment packet prior to turning 65.**

Eligibility for Medicare for Reasons other than Age

When you or a dependent become eligible for Medicare for reasons other than age, **you may elect to have the group health plan as primary medical coverage, or enroll in the Medicare Part C Plan.**

Further details regarding the Medicare advantage plan are available in the insurance contract or certificate of coverage. Refer to the certificate of coverage for a complete description of the plan's coverage, which you may obtain at no charge from the carrier or the Fund Office.

CONTINUATION OF BENEFITS

In accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as **COBRA**, and New York State insurance regulation, **you, your spouse**, **and your covered dependents** (referred to as "qualified beneficiaries**"), if applicable, have the opportunity to temporarily extend your group health coverage when it would otherwise be lost due to any of the following qualifying events:**

- Employee's termination of employment for reasons other than gross misconduct;
- Employee's reduction in work hours;
- Employee's legal separation or divorce;
- Employee's entitlement to Medicare;
- A dependent's loss of dependent child status under the plan; or
- Death of the employee.

To be a qualified beneficiary who is eligible for health insurance continuation coverage, an individual must be covered under the group medical plan on the day before a qualifying event as either a covered employee, the spouse of a covered employee (this includes same-sex spouses), or the dependent child of a covered employee.

If you elect continuation coverage, you will be restricted to the coverage in force at the time of coverage termination.

Maximum Continuation Period

In accordance with New York State insurance regulation, qualified beneficiaries can maintain their **continuation coverage for up to a maximum of 36 months**, regardless of the qualifying event.

Notification Requirements

At the time of a qualifying event, you will receive written notification of your right to elect continuation coverage. Separate notification will be provided to all covered family members who live at a different address.

When the qualifying event is a result of the employee's separation from employment, reduction in work hours, death, or enrollment in Medicare, the COBRA Administrator will send you a *COBRA Election Notice* within 14 days of the qualifying event.

When the qualifying event is the employee's legal separation or divorce or a dependent child losing dependent status under the plan, you, a family member, or your designated representative must notify the COBRA Administrator within 60 days of the qualifying event. The notice should be in writing and include the following:

- full name of the qualified beneficiary or beneficiaries who have experienced the qualifying event
- the type of qualifying event (e.g., divorce, loss of dependent status)
- the date the qualifying event occurred

The COBRA Administrator will send you a *COBRA Election Notice* within 14 days of receiving notice of the qualifying event.

Election Rights

Each qualified beneficiary will have an independent right to elect continuation coverage. A covered employee may elect continuation coverage on behalf of his or her spouse. A covered employee or his or her spouse may elect continuation coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect continuation coverage on behalf of a minor child.

Each qualified beneficiary will have 60 days to decide whether to elect continuation coverage. The 60-day period is measured from the later of the coverage loss date or the date the *COBRA Election Notice* was provided to the qualified beneficiaries. The completed *COBRA Election Notice* may be hand delivered or mailed to your employer.

If a qualified beneficiary waives continuation coverage during the election period, the waiver may be revoked before the end of the election period. In such an event, continuation coverage will not be retroactive but will begin on the date the waiver is revoked.

Coverage

Qualified beneficiaries will be offered coverage identical to the coverage provided under the plan to similarly situated active employees and their family members (generally, qualified beneficiaries receive the same coverage they had immediately before qualifying for continuation coverage). Any change in benefits under the plan that applies to active employees will also apply to qualified beneficiaries. You will be entitled to the same benefits, choices, and services that a similarly situated member is currently receiving under the plan, such as the right to choose among available coverage options during open enrollment. You will receive notification of open enrollment periods, the plans that are available at that time, and the costs of those plans as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Continuation coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event.

Premium Payments

If you elect continuation coverage, you will be responsible for the full cost. A 2% administrative fee may be added. The premium will not exceed 102% of the cost to the plan for similarly situated employees covered under the plan who have not incurred a qualifying event. For qualified beneficiaries receiving the 11-month disability coverage extension, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. You will normally be notified of any rate increase during open enrollment. The rate increase will generally take effect at the start of the new plan year. Premiums will generally remain the same for the next 12-month period, unless there is a change in coverage, the rates decrease, or there is a change in insurance carriers.

You must make your initial premium payment within 45 days after the date you elected continuation coverage. Payment generally must cover the period of coverage from the date of your election retroactive to the date of the loss of coverage due to the qualifying event.

Premiums for successive periods of coverage are due on the 15th of the month. You will not receive monthly premium notices. Payment is considered to be made on the date it is sent (postmarked) to the employer.

If premiums are not paid by the due date, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

You will be granted a grace period of 30 days after the due date to make your payment. If you fail to make your payment before the end of the grace period, your coverage will be canceled and you will lose your right to continuation coverage.
If the amount of your premium payment is made in error but is not significantly less than the amount due, the plan will notify you of the deficiency and will grant you up to 30 days to pay the difference.

Early Termination

Continuation coverage may be terminated before the end of the maximum period if:

- Premiums are not paid within the 30-day grace period of becoming due;
- The employer ceases to maintain the group health plan for any employees;
- After electing continuation coverage, a qualified beneficiary obtains coverage with another group health plan that does not contain any exclusion or limitation for any pre-existing condition. (If coverage under the other group health plan was obtained prior to the election, coverage may not be discontinued, even if the other coverage continues after the election); or

- After electing continuation coverage, a qualified beneficiary becomes entitled to Medicare benefits. (If Medicare is obtained prior to the election, coverage may not be discontinued, even if Medicare continues after the election).

You will be notified as soon as possible after the decision is made to terminate your coverage. The notice will describe the date your continuation coverage will end, the reason for termination, and any rights you may have under the plan to convert to an individual policy.

End of Continuation Coverage

If you or a family member decide to cancel your continuation coverage or you become covered under another group health plan, notify the Fund Office in writing as soon as possible.

You will receive written notification when you reach the end of your maximum period of continuation coverage.

Conversion to Direct Pay Plan

At the end of the continuation period, qualified beneficiaries are given the option of converting to an individual policy if this option is available under the plan to similarly situated individuals not receiving coverage. The conversion option will be offered within 180 days before continuation coverage ends. This option is not available if continuation coverage is terminated before the end of your maximum period of continuation coverage. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage.

Notification of Address Changes

In order to protect your rights, keep the Fund Office and the carrier informed of any changes to your address or the addresses of any family members that do not live with you. It is also recommended that you keep a copy of anything you send to the Fund Office or the carrier for your records.

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to the provisions set forth in most group health plans that are applied when a person is covered by more than one group health insurance contract, plan, or policy. Coordination of benefits does not normally apply if you have any individual or personal insurance policies. The purpose of coordinating benefits is to ensure that the total benefits payable under both plans does not exceed your expenses for the service and to prevent duplicate payments or overpayments.

The first step in the coordination of benefits is to determine which group plan should be the "primary" plan**. Generally, the primary plan is the one that pays benefits first; the secondary plan may pay some or all of the difference between the amount paid by the primary plan and the total allowable expenses for the claim.**

***If you, or any dependent is using this Plan as Primary and another plan as Secondary, no automatic reimbursements from the HRA will be made. You must submit the Explanation of Benefits for both insurances for each claim to the Fund Office for authorization of reimbursement. Your HRA will ALWAYS Pay last and only after submission of insurance consideration to the Fund Office. (There are exceptions for Medicare as Second Payer)**

Refer to the insurance contract or certificate of coverage for additional information on coordination of benefits.

Submitting Claims with more than one insurance

If you are covered under more than one group health plan, claims should be submitted to your **primary plan first.** Any balance remaining after payment by the primary plan should **then** be submitted to the **secondary plan**. **After all insurances have been considered, submit your claims to the Fund Office for reimbursement from your HRA**.

Any non-covered benefits will not be considered allowable expenses by the carrier, even if they are covered under the other group plan.

CLAIMS AND APPEALS PROCEDURE

This section explains to you the steps you must take to file a claim for benefits, and how to file an appeal if your claim is denied, in whole or in part. As you will see, **different claim procedures apply depending on the type of benefits claimed**. It is very important that you follow these procedures carefully because your failure to do so may delay or reduce your ability to obtain benefits. In addition, keep in mind that you must exhaust your rights under these procedures (including requesting and receiving a determination on review) before you commence any litigation, arbitration or administrative proceeding regarding an alleged failure by the Plan to pay benefits or any matter within the scope of the appeals process.

What is a claim for benefits?

A **"claim for benefits" is a request for a Plan benefit made in accordance with the Plan's procedures for filing benefit claims.** If you make an inquiry unrelated to a specific benefit claim, such as an inquiry regarding benefits available under the Plan, or the circumstances under which benefits might be paid, or eligibility for benefits, this generally won't be treated as a "claim for benefits" subject to these provisions. In addition, if you request prior approval of a benefit that does not require prior approval under the Plan, this is not considered a "claim for benefits" under these procedures.

Insured Health Benefits

Claims for health benefits that are insured (your medical, dental and vision coverages), as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the insurance

contracts with those insurers. You should refer to the insurance contract or certificate of coverage for full details regarding claims procedures, grievances, and appeals

These procedures for all types of claims (including urgent care claims, pre-service claims, post-service claims and concurrent care claims) are set forth in the Insurance Benefit Booklet provided by the insurance companies. If you have any questions regarding making or processing of claims and/or requests for review, you should review a current copy of the Insurance Benefit Booklet from the applicable insurance company. If you need an additional copy of the booklet, you may obtain one free of charge from the Fund Office.

Generally, when you receive care from a network or participating provider, that provider will file your claim for you. When the claim is processed and the plan pays its share of the cost of covered services to the provider, you will receive an Explanation of Benefits (EOB) statement.

You are normally responsible for paying any coinsurance, copayment, or charges for non-covered services to the provider at the time service is received.

If you obtain emergency care from a non-participating or out-of-network provider, you may be asked to pay for the service at the time care is received or you may receive a bill. You will need to submit the original itemized bill to the carrier's Claims Department so that your claim can be processed. Claim forms are available from Member Service or you may download the form from the carrier's website.

Claims must be submitted to the carrier within 12 months of the date of service.

Claims for Health Reimbursement Account Benefits

When you or a covered family member receive a service covered by your medical insurance carrier, and a **claim has been successfully processed by** said **carrier, you or your provider will <u>automatically</u> (no further action by you is necessary) be considered as having made a claim for benefits under the Health Reimbursement Account** for any applicable co-pay or deductible. **If the claim is approved, the Claim Administrator will pay you directly. <u>You are responsible for paying your provider for services.</u>**

****see "submitting claims with more than one insurance" under the coordination of benefits section for details on how to claim benefits if you have more than one insurance.***

Claims for Life Insurance Benefits

If you are filing a claim for Life Insurance benefits, you must follow the claim procedures described in this section.

In order to make a claim for benefits, you are generally required to submit to the Fund Office a completed claim form available from the Fund Office, along with any required documentation.

Claim Denial and Appeals Procedures

If your claim is denied, the Claim Administrator will notify you of an adverse benefit determination no later than 30 days after receipt of your claim. If the Claim Administrator determines that an extension of time is necessary due to matters beyond the control of the plan, this period may be extended for up to an additional 15 days. You will be notified of the extension before the initial 30-day period expires, and the notice will describe the circumstances requiring the extension and inform you of the date by which the Claim Administrator expects to make a decision on your claim. If the extension is necessary because you failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have 45 days from your receipt of the notice to provide the requested information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Claim Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, the Claim Administrator will notify you (or your authorized representative) of the benefit determination in writing within the time periods described above. This notification will include:

- the specific reason(s) for the denial or other adverse benefit determination;
- references to the specific Plan provisions on which the determination was based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary;
- a description of the Plan's review procedures and the 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, either a copy of the rule or a statement that it is available upon request at no charge; and
- if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, you have the right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 180 days** after you receive the notice of denial, submit your written request for review to the Board of Trustees. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating

to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

A different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial 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. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

The decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Board of Trustees' request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for benefits is denied on appeal, you will receive a written notice of the claim denial including the same information set forth in the initial notice of denial, as well as a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. All decisions on review are final and binding on all parties. You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Voluntary External Review

If your appeal of a claim for benefits (not related to employee classifications) under the plan is denied for: (a) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time), you will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility under the terms of the Plan; (iii) you exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and

- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

For more information about external appeals or to request an external appeal application, contact:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
P.O. Box 7209
Albany, NY 12257

800.400.8882
Or
www.ins.state.ny.us

FAMILY AND MEDICAL LEAVE AND NEW YORK PAID FAMILY LEAVE

If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "PFLL") you will be entitled to health and hospitalization insurance coverage under the Plan throughout the duration of your leave, but your Employer must contribute to the Plan a monthly premium equal to the required contribution necessary for your coverage to continue. You will receive the type of coverage (i.e., family or single) you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after a period of unpaid FMLA leave entitlement has been exhausted or expires, your Employer is entitled to recover the premiums paid on your behalf unless the reason you did not return is due to a continuation, recurrence, or onset of a serious health condition which entitles you to leave under the FMLA, or other circumstances beyond your control as defined in the FMLA and the regulations thereunder. Questions regarding your entitlement to FMLA or PFLL leave should be referred to your Employer. Questions about the continuation of medical and dental coverage during leave, if available, should referred to the Fund Office.

If you do not return to work at the end of an FMLA of PFLL leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described above under the section entitled Continuation of Coverage.

MILITARY LEAVE

In accordance with Uniformed Services Employment and Reemployment Rights Act of 1994, you have the right to continue your group health coverage during a military leave of absence. If your military leave is for a period of less than 31 days, your health insurance coverage will continue as if you were actively employed. If your military leave extends for 31 days or more, you will be offered health insurance continuation coverage for up to 24 months.

If you cancel your group health plan coverage or elect COBRA or New York State continuation coverage during your military leave, your coverage under the plan will be reinstated upon reemployment. Upon reinstatement in the plan, there will be no exclusion or waiting period for pre-existing conditions (other than any exclusion or waiting period that would have applied even if there had been no absence for military service). The only exception is for any illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Further details regarding military leaves of absence are available in the insurance contract or certificate of coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If you receive a court issued Medical Child Support Order (MCSO) that requires you to provide your child or children with health coverage, the Fund Office must determine if the MCSO is "qualified" before providing the benefits called for by the order. You should contact the Fund Office if you are affected by an MCSO. The Fund Office will determine if the MCSO is qualified within 10 to 90 days (depending on the difficulty of the determination). You will then be notified on how to proceed.

Further details regarding Medical Child Support Orders are available in the insurance contract or certificate of coverage.

MENTAL HEALTH PARITY ACT

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. This means that mental health and substance use disorder benefits may not have annual or lifetime dollar limits that are lower than any such dollar limits for medical and surgical benefits. Therefore, a plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a limit on mental health or substance benefits. Employers that have more than 50 employees on business days during the preceding calendar year and that employ at least two employees on the first day of the plan year are covered by the MHPAEA.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires the plan to cover the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Normal plan deductibles and coinsurance apply.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Per New York law, the Plan will provide coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48 hour or 96 hour minimum coverage period, the Plan will provide coverage of the home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Coverage of this home care visit shall not be subject to any Coinsurance or Deductible amounts.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the Fund, that provide health benefits, protect the privacy of your personal health information. A description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which has already been provided to you. (This statement is not intended to be, and cannot be, considered the Plan's Notice of Privacy Practices. If you wish to review the Plan's Notice of Privacy Practices but cannot find your copy, please contact the Fund Office.)

1. HIPAA Privacy and Security.
The provisions below related to HIPAA Privacy and Security shall apply to the Plan. For purposes of this section entitled "HIPAA Privacy and Security," the following terms have the following meanings:

"Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the Plan provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are

claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A subcontractor of a Business Associate may be treated as a Business Associate. A Business Associate may be a Covered Entity. However, insurers and health maintenance organizations are not Business Associates of the plans they insure.

"Covered Entity" means a group health plan (including an employer plan, multiemployer plan, insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

"Protected Health Information" or "PHI" means individually identifiable health information created or received by a Covered Entity. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

"Electronic Protected Health Information" or "ePHI" is protected health information that is transmitted or maintained in electronic media including, but not limited to, hard drives, disk, on the internet, or on an intranet.

2. Uses and Disclosures of PHI.

The Plan may disclose a covered employee's PHI or ePHI to the Board of Trustees (or its designee) for the plan administration functions, to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Board of Trustees except upon receipt of a certification by the Board of Trustees that the Plan incorporates the agreements of the section of this document entitled "Privacy Agreements with the Board of Trustees", except as otherwise permitted or required by law.

3. Privacy Agreements with the Board of Trustees.
As a condition for obtaining PHI from the Plan and its Business Associates, the Board of Trustees agrees it will:

To the extent not inconsistent with the Privacy Rule, the Board of Trustees will use and disclose protected health information only for purposes related to Plan Administration;

Not use or further disclose such PHI other than as permitted by the Fund's plan documents or as required by law;

Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to substantially the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;
Report to the Plan's Privacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Plan of which the Board of Trustees becomes aware;

Make the PHI of a particular Participant available based on HIPAA's access requirements in accordance with 45 C.F.R. § 164.524;

The Board of Trustees will make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

The Board of Trustees will make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
Make the Board of Trustees' internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

If feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board of Trustees agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
Ensure that there is adequate separation between the Plan and the Board of Trustees as required by 45 C.F.R. § 164.504(f)(2)(iii).

4. Employees with Access to PHI.
The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information: Ithaca Bricklayers Welfare Fund's health and welfare staff, including (without limitation) the:

- Fund Administrator
- Administrative Assistant
- Plan Representatives

5. Mechanism for Resolving Noncompliance.
The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this summary. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the Participants whose privacy has been violated.
6. Security Agreements of the Board of Trustees.
As a condition of obtaining or maintaining e-PHI from the Plan, its Business Associates, insurers or HMOs, the Board of Trustees agrees it will:

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

Ensure that the adequate separation between the Plan and the Board of Trustees is supported by reasonable and appropriate security measures;

Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

Report to the appropriate party any security incident of which it becomes aware. For purposes of the Plan, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and
Upon request from the Plan, the Board of Trustees agrees to provide information to the Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Board of Trustees.

STATEMENT OF ERISA RIGHTS

All members in the plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan members are entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan. This includes insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) if the employer is required to file this report with the U.S. Department of Labor.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series) and a copy of the updated SPD. The plan administrator may impose a reasonable charge for the copies.

- Continued health care coverage for you, your spouse, and/or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse and/or dependents may have to pay for such coverage. Review this SPD and the documents governing the plan for the rules governing your COBRA health continuation coverage rights.

- The plan administrator may be required by law to furnish each member with a copy of the Summary Annual Report for the plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other plan members 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a penalty of 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 which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Questions

If you have any questions about the plan, contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, you may contact the Employee Benefits Security Administration (EBSA) at:

The nearest district office:

New York (eastern)
New York Regional Office
33 Whitehall Street, Suite 1200
New York, NY 10004
Telephone: 212.607.8600
Fax: 212.607.8681

New York (central/western)
Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203
Telephone: 617.565.9600
Fax: 617.565.9666

EBSA's Office of Member Assistance:

200 Constitution Avenue, NW,
Suite N-5623
Washington, DC 20210
Telephone: 202.693.8630
Fax: 202.219.8141

Certain publications about your rights and responsibilities under ERISA are also available by calling the EBSA's Publication Hotline **1.866.444.EBSA (3272)** or on the EBSA's website: **www.dol.gov/ebsa**.

BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 8 NY WELFARE PLAN
SUMMARY PLAN DESCRIPTION EMPLOYEE ACKNOWLEDGMENT

I hereby acknowledge that I have received a copy of Bricklayers & Allied Craftworkers, Local 8 NY Welfare Plan summary plan description (SPD), which includes an overview of the group health plan benefits provided by my Local Chapter, including the plan's eligibility requirements, costs, claims procedures, and the rights and responsibilities of participants and beneficiaries under the plan. I am aware that if I have any questions regarding the contents of the SPD I should contact the Fund Office.

I am aware that the information in this SPD is subject to change. I understand that changes in the plan may supersede, modify, or eliminate the information summarized in this booklet. As the Fund provides updated Summary Plan Descriptions or Summary of Material Modifications, I accept the responsibility for reading about the changes.

I acknowledge that I have read or will read this SPD.

_____
Employee Name (Please Print)

_____ _____
Employee Signature Date of Signature