Derrickmen's Welfare Fund
Local 197

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

January 1, 2020

January 1, 2020

Dear Participant:

We are pleased to provide you with this up-to-date Plan booklet summarizing the plan of benefits (the Plan) available to you and your family under the Derrickmen's Welfare Fund, Local 197. Under federal law, this booklet is known as a summary plan description (SPD). The Plan described in this booklet is effective January 1, 2020 and replaces all other plan documents and summary plan descriptions previously provided to you.

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

We urge you to become familiar with the benefit program and to keep this booklet for future reference. In this booklet, the words "you" and "your" refer to the covered participants/employees.

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

Derrickmen' s Welfare Fund, Local 197
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001
(212) 505-5050

Sincerely,

THE BOARD OF TRUSTEES

This booklet is the Plan Document/Summary Plan Description ("SPD") for the Derrickman's Welfare Fund, Local 197 as of January 1, 2020. It is meant to help you understand how the Plan works. It does not change the official rules and regulations in the official Plan documents, including insurance certificates of coverage, insurance policies, trust agreements and the collective bargaining agreements establishing the Plan. The certificates of coverage and insurance policies for the insured parts of the Plan take precedence over what is included in this document. Rights to benefits are determined only by referring to the full text of official Plan documents (available for your inspection at the Fund office) or by official action of the Board of Trustees. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan at any time.

The Trustees have the right to change the eligibility rules or amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Nothing in this statement is meant to interpret or change in any way the provisions expressed in the Plan or insurance policies.

DERRICKMEN'S WELFARE FUND, LOCAL 197

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The Segal Company

TABLE OF CONTENTS

INTRODUCTION

This Summary Plan Description describes the benefits provided by the Derrickmen's Welfare Fund, Local 197 hereafter referred to as the "Plan" or "Fund". The Plan described in this document is effective January 1, 2020 and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are eligible for benefits under this Plan, refer to the Eligibility section in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status, satisfactory to the Plan.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. No individual will have accrued or vested rights to benefits under this Plan. Plan benefits are **not** vested and are **not** guaranteed.
- The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules, even if extended eligibility has already been accumulated. Resolutions to amend the Plan are made by the Board of Trustees and become effective on the date as specified in the document or resolution amending the Plan. **Welfare benefits do not vest.**
- In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Plan Administrator and other individuals with delegated responsibility for the administration of the Plan, 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. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

This document will help you understand and use the benefits provided by Derrickmen's Welfare Fund, Local 197. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Appendix which include the Certificates of Coverage/Insurance from the Insurers.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Contact Chart to sources of help or information about the Plan can be found on the next page.

FOR HELP OR INFORMATION/CONTACT CHART

When you need information, please check this booklet first. If you need more information, contact the following organizations for additional help:

CONTACT CHART SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION	
FOR INFORMATION ON:	**YOU SHOULD CONTACT:**
General Plan Information and Eligibility • Eligibility • Enrollment • Information about COBRA and HIPAA, including premium payments and notices • Self Pay Retiree Benefit • Information about USERRA, FMLA, QMCSOs and your Rights under the Plan • Request documents or other Plan related information • Replacement ID Cards • Claim Forms • General questions about Plan coverage **COBRA Administrator** • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments **HIPAA Privacy Officer/ HIPAA Security Officer** **Dental Benefits** • Dental Claims and claims administration • Appeals **Optical Benefits** • Request a voucher for Vision World or General Vision Services (GVS) benefits • Appeals **Vacation and Supplemental Benefits** • Claim Forms and claims administration • Appeals	**Derrickmen's Welfare Fund, Local 197** **c/o Daniel H. Cook Associates Inc.** 253 West 35th Street, 12th Floor New York, NY 10001 Telephone: (212) 505-5050 Fax: (212) 714-1455 Hours of Operation: 9:00 a.m.-5:00 p.m.
Insured Medical and Hospital Benefits • Medical and Hospital Network Provider Directory • Additions/Deletions of Providers • Claim Forms and Claims Administration • Benefit Information/Inquiries • Medical Management Program • Precertification • Second and Third Opinions • Case Management • Appeals	**Empire Blue-Cross Blue Shield EPO** Member Services P.O. Box 1407 Church Street Station New York, NY 10008-1407 www.bcbs.com

CONTACT CHART SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION	
FOR INFORMATION ON:	**YOU SHOULD CONTACT:**
Prescription Drug Benefits • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Appeals	**General Prescription Programs (GPP)** **222 Lafayette Street** **Newark, NJ 07105** **1-800-341-2234** www.generalprescriptionprograms.com
Optical Benefits • Vision providers • Claims administrator	**Vision World** **General Vision Services (GVS)** **520 8th Avenue, 9th Fl.** **New York, NY 10018** 1-800-VISION 1 www.generalvision.com
Insured Short-Term Disability Benefits **Insured Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits**	Request for and completed claims for Short-Term Disability, Life, and AD&D benefits and beneficiary designation forms should be sent to the Fund Administrator at: **Derrickmen's Welfare Fund, Local 197** c/o Daniel H. Cook Associates Inc. 253 West 35th Street, 12th Floor New York, NY 10001 (212) 505-5050 Union Labor Life insures and administers the Short Term Disability, Life, and AD&D benefits. You should contact them to file an appeal. Contact them at: **The Union Labor Life Insurance Company** (Union Labor Life) 8403 Colesville Road Silver Spring, MD 20910

This Plan contains Coordination of Benefits (COB) provisions to prevent double payment of certain covered expenses. This provision works by coordinating the benefits under this Plan with other plans in which a person is a participant so that total benefits available will not exceed one hundred percent of allowable expenses. See the Coordination of Benefits section in the applicable Certificate, located in the Appendix, for more information. Details of specific covered services and exclusions are also found in the attached certificates, located in the Appendix.

ELIGIBILITY

ACTIVE PARTICIPANTS

Initial Eligibility

If you are an Employee working in Covered Employment for a Contributing Employer (as defined below), you are eligible for benefits provided by this Fund once you have worked at least 1,200 hours within a 12-month period (provided you properly enroll within the necessary timeframes as described in the *Enrollment* section).

A "Contributing Employer" is an employer that is required under a collective bargaining agreement to contribute to the United Derrickmen and Riggers Association, Local 197 Welfare Fund. If you work for a Contributing Employer, all work you do for that employer is considered "Covered Employment".

Effective Date of Coverage

Coverage begins the first of the month following the 12 consecutive month period during which you have worked 1,200 hours in Covered Employment. Once you are eligible for (and properly enrolled for) coverage, your coverage will continue for 12 months from the effective date of your coverage. Once you meet the hours requirement and properly enroll for coverage as described in the *Enrollment Section*, you will be covered for benefits and considered a "Participant" in the Plan. When used in this Booklet, "Participant" refers to you, the eligible Employee.

For example, you begin covered employment on July 5, 2019. You work 1,200 hours during the months of July – June 30, 2020. Your coverage begins on July 1, 2020.

Short-term disability benefits (New York State Short-Term Disability benefits) are effective on the day employment begins, subject to the provisions of the New York State Disability Benefits Law. Active employees will be eligible for disability benefits after the 28th consecutive day of work.

Dental benefit becomes effective on the six-month anniversary of your eligibility for all other health benefits.

Maintaining Coverage

After you first become eligible, in order to maintain coverage for subsequent 12-month periods, you must work the required hours as indicated below:

- ***Single Coverage***

  You must accumulate at least 800 hours in 12 previous consecutive months to maintain the following:
  - Empire Blue Cross Blue Shield EPO Benefits (Medical and Hospital Benefits)
  - Life and AD&D Benefits
  - Prescription Drug Discount Card

  You must accumulate at least 900 hours in 12 previous consecutive months to maintain all benefits as follows:
  - Empire Blue Cross Blue Shield EPO Benefits (Medical and Hospital Benefits)
  - GPP Prescription Drug Benefits
  - Dental and Optical Benefits
  - Life and AD&D Benefits

- ***Family Coverage***

You must accumulate at least 1,000 hours in 12 previous consecutive months to maintain the following:

- Empire Blue Cross Blue Shield EPO Benefits (Medical and Hospital Benefits)
- Life and AD&D Benefits
- Prescription Drug Discount Card

You must accumulate at least 1,200 hours in 12 previous consecutive months to maintain all benefits as follows:

- Empire Blue Cross Blue Shield EPO Benefits (Medical and Hospital Benefits)
- GPP Prescription Drug Benefits
- Dental and Optical Benefits
- Life and AD&D Life Benefits

ELIGIBLE DEPENDENTS

Your dependents are also eligible for coverage when you become eligible. Your eligible Dependents include:

- Your lawful spouse to whom you (the Participant) are legally married.

- Your child or children, whether married or unmarried, to the end of the month in which they reach age 26 including:

  - your own biological child(ren),

  - stepchild(ren), as long as the child's parent remains married to you (the Participant).

  - an adopted child or a child placed for adoption from the start of any waiting period prior to the finalization of the child's adoption. Also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption. Placed for adoption means the assumption and retention by the participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

- Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance. Notice must be given within 31 days of the date the child reaches the terminating age. The child will remain covered as long as you are covered and the child remains in such condition, unmarried and chiefly dependent on you for support and maintenance.

- Children subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO). Participants may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) from the Plan Administrator.

This Plan does not cover foster children, children for whom you are the legal guardian, or children or spouses of Dependent Children.

Effective Date of Coverage for Eligible Dependents

If you have Eligible Dependents when you first become eligible for benefits coverage, the effective date of coverage for your Eligible Dependents is the same day as yours provided you properly enroll them in accordance with the following section. If you later add an Eligible Dependent, coverage will be effective when you add your new Dependent, provided you properly enroll them in accordance with the next section.

ENROLLMENT

INITIAL ENROLLMENT

When you first become eligible for coverage, the Fund Office will notify you and send you the necessary enrollment form(s). For coverage to be effective, you must complete and sign the enrollment form(s) and submit the completed enrollment form(s) (along with any proof of dependent status as described below) to the Fund Office within 30 days of when you are first eligible. Coverage for you and your eligible Dependents will begin on the first day of the first month following the month you fulfill your eligibility requirements provided the Fund Administrator receives your completed enrollment material by the deadline. If you need a copy of enrollment forms, they can be obtained from the Fund Administrator.

PROOF OF DEPENDENT STATUS

For your Eligible Dependents to be eligible for coverage under the Plan, you must complete the necessary enrollment forms and provide the Fund Office with proof of dependent status. The Fund Office will accept a copy of the following documents as proof of dependent status:

- **Spouse/Marriage:** Certified marriage certificate and copy of social security card (you will also need to notify the Fund Office of other coverage for your Spouse or family, if applicable).

- **Child/Birth**: Child's certified birth certificate showing the parents' names and copy of social security card.

- **Adoption or placement for adoption**: Certified court order signed by a judge, birth certificate and social security card.

- **Stepchild**: Certified birth certificate showing your spouse as the biological/adoptive parent of the child and a marriage certificate between you (the Participant) and the child's parent (if not already on file) and the child's social security card.

- **Child covered pursuant to a Qualified Medical Child Support Order (QMCSO)**: Valid QMCSO document signed by judge or National Medical Support Notice.

- **Disabled Dependent Child**: Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability, and dependent chiefly on you and/or your Spouse for support and maintenance. You must contact the Fund Office for the necessary form(s) to be completed by both you (the Participant) and the Dependent's attending physician. The form must be received by the Fund Office within 31 days after attainment of the limiting age of Dependent coverage under this plan. You may be required to show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a dependent for federal income tax purposes.

Social Security Numbers of Dependents: To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must provide the Fund Office with a copy of the Social Security card for each and every Eligible Dependent you wish to enroll in the Plan and information on whether you or any Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

A Participant must reimburse the Plan for any benefits that were paid for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan. By electing coverage for your Dependents, you are confirming that they meet the Plan's Dependent eligibility requirements and agree to notify the Plan Office within 30 days but not less than 60 days of an event that causes any of these Covered Dependents to no longer meet the definition of an Eligible

Dependent or eligibility of other coverage (for Coordination of Benefits purposes). The Plan, in its sole discretion, maintains the right to audit any and all Dependent information on file, and may require that you promptly provide sufficient documentation verifying your Covered Dependents' continued eligibility at any time.

If you do not promptly provide documentation sufficient to verify your Covered Dependents' eligibility or if the Plan determines that any of the information you provide (or provided) regarding your Covered Dependents is untrue, incomplete or misleading, or if you fail to promptly notify the Plan of an individual's loss of eligibility, the Plan may take such action as it deems appropriate under the circumstances. Those actions may include, but are not limited to, requiring you to repay the Plan for any benefits paid with respect to your ineligible Dependent. If you provide fraudulent information or make intentional misrepresentations regarding your Covered Dependents, the Plan may retroactively terminate benefits for your ineligible Dependents subject to the rules pertaining to rescission of coverage described later in this section.

SPECIAL ENROLLMENT

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption after your Initial Eligibility, you may enroll yourself and/or your new Dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption and complete the proper enrollment paper work as described in this section.

If you decline enrollment (or do not enroll) yourself and/or Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or Dependents in this Plan if you and/or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your Dependents' other coverage). However, you must request enrollment for and enroll for benefits within 30 days as described in this section after you and/or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

State Children's Health Insurance Program

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

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

START OF COVERAGE FOLLOWING ENROLMENT

Coverage cannot begin for you and your Eligible Dependents until the Fund Office receives a completed Enrollment Form along with the necessary documentation (e.g., birth certificate, marriage certificate, adoption papers) as described in this section. If you have Dependents and enroll them when you are first eligible for coverage and it is within 30 days of your Initial Eligibility, their coverage will be effective retroactive to the date you are first eligible.

For newly added Dependents, if the Fund Office receives a complete Enrollment Form and the necessary documentation within 30 days of the date of the marriage, birth, adoption, placement for adoption or loss of other group coverage, coverage will be effective:

- *For newborn child(ren)*: Newborn child(ren) are covered for benefits retroactive to the date of birth.

- *For adopted Dependent Child(ren):* Adopted child(ren) are covered from the date that child is adopted or placed for adoption (proposed adoptive children), whichever is earlier.

- Coverage of adopted newborns is available from the moment of birth if the proposed adoptive parent(s) take physical custody of the infant as soon as the infant is released from the hospital after birth and the proposed adoptive parent(s) file a petition pursuant to New York Domestic Relations Law section 115-c within 30 days of the infant's birth.

  An adopted newborn will not be covered from the moment of birth if one of the natural parents revokes consent to adoption or if a notice of revocation of the adoption is filed. If one of the child's natural parents has coverage for the newborn's initial hospital stay, hospital benefits for that stay will not be provided but other benefits in connection with that stay and for all care subsequent to that stay that are covered under the Plan will be covered.

- A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

- *For your new Spouse (and step-children, if applicable)*: Your new spouse (and step-children) is covered for benefits retroactive to the date of marriage.

- If you are enrolling because of loss of other coverage or CHIP/Medicaid or because of eligibility for a premium assistance program through CHIP or Medicaid, coverage begins the first of the month following the date coverage terminates or eligibility begins for a premium assistance program.

LATE ENROLLMENT

If you did not enroll for coverage at the time you first became eligible, you may enroll late (after the first 30 days or 60 days, as applicable), subject to the special enrollment rules listed in the sections above. If you enroll late, coverage will not begin until the first day of the month following the date the Fund Administrator receives your completed enrollment forms.

Qualified Medical Child Support Order (QMCSO) (*Special Rule for Enrollment*)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Order (NMSO). These are support orders of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office has the following QMCSO Procedures described below.

According to federal law, a Qualified Medical Child Support Order 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 also includes a National Medical Support Notice.) A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to provide for a child's health plan coverage;

- Indicates the name and last known address of the parent required to provide 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, 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 child of the employee, 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 the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage for the child(ren).

Enrollment Related to a Valid QMCSO: If the Fund has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Fund determined the order was valid, without regard to typical enrollment restrictions. The Fund Office will accept 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 date the enrollment request and required documentation are received by the Fund Office. If you have not enrolled in the Plan, you may do so when you enroll your child. Coverage will be subject to all of the Plan's otherwise applicable terms, provisions, limitations and rules.

No coverage will be provided for any alternate recipient under a QMCSO unless all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied.

Termination of Coverage: 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 children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA section of this document.

TERMINATION OF COVERAGE

Active Participants

If you are an Active Participant, your coverage ends on the earliest of:

- The date this Plan terminates;
- The last day of the month you no longer meet the eligibility requirements (e.g., the last day of the month following the period of 12-consecutive months you do not work the necessary number of hours to meet the eligibility requirements);
- Thirty-one days after you enter military service (subject to the Leave for Military Service section; or
- The date of your death.

Participants who are disabled and receiving short-term disability benefits from the Welfare Fund or from worker's compensation or unemployment will receive a three month extension of benefits and coverage will terminate at the end of the three month extension.

Eligible Dependents

Coverage for your Eligible Dependents ends on the earliest of the following:

- The date your (the Participant's) coverage ends;
- The last day of the month following the date a Dependent Child no longer qualifies as a Dependent upon reaching age 26, the limiting age under the Plan;
- The date a Dependent Child who is over the limiting age of 26 is no longer considered handicapped or disabled, marries, is capable of self-sustaining employment or is no longer dependent upon you for support or maintenance;
- The date you and your Spouse divorce or are legally separated;
- The date an Eligible Spouse enters active military service;
- The date of the Dependent's death;
- The date the Plan discontinues coverage for Dependents or the Plan terminates.

In the event of the Active Participant's death, coverage for eligible Dependents will continue until the end of the last day of the month in which your (the Participant's) coverage would have ended because you did not work the required number of hours.

You and/or your dependents will be offered COBRA Continuation Coverage when you lose coverage. See the COBRA Continuation Coverage section for details.

Reinstatement of Coverage

A Participant who loses eligibility may be reinstated for benefits on the first day of the first month following a period of 12-consecutive months during which he worked at least 800 hours in Covered Employment, provided he returns to Covered Employment within 36-consecutive months after the month in which contributions to the Welfare Fund were last made on his behalf.

A Participant who loses eligibility and who returns to covered employment after 36-consecutive months from when the Welfare Fund last received contributions on his behalf must again meet the Initial Eligibility requirements of the Fund. This means that the employee will be reinstated for benefits on the first day of the first month following a period of twelve consecutive months during which he has worked at least 1,200 hours.

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. Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of a material fact to the Plan.

Coverage for you (the Participant) and/or your Dependents may be terminated retroactively (rescinded):

- In cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30-day notice);

- 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) constitutes a failure to pay COBRA premiums. In these situations, coverage may and 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 Fund amounts incorrectly paid by the Fund. The Board of Trustees may commence legal action against a Participant 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 Participant or dependent to recover amounts owed.

NOTICE TO THE PLAN

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

- change of name;

- change of address (advise the Fund Administrator promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage);

- addition of any dependent by birth or adoption;

- marriage, divorce, legal separation, or death of yourself or any covered spouse and/or dependent child;

- any information regarding the status of your dependent child(ren), including, but not limited to:

  - your dependent child reaching the Plan's limitation age of 26; or

  - the existence of any physical or mental handicap; or

  - the marriage of your dependent child;

- Medicare enrollment or disenrollment;

- Social Security disability benefits award or termination; and

- the existence of other medical or dental coverage.

Change in Beneficiary

Contact the Fund Administrator to obtain the necessary form if you wish to change the beneficiary for your Life Insurance and Accidental Death and Dismemberment Benefits. Otherwise, its permanent records may not reflect your current wishes regarding your choice of beneficiary.

Please notify the Fund Administrator as soon as possible of any changes to the information described above and forward that information in writing to the Fund Administrator.

LEAVE OF ABSENCE FOR ACTIVE PARTICIPANTS

Special circumstances may entitle you (the active Participant) to continue your eligibility for coverage under the Plan when you are on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States.

FAMILY AND/OR MEDICAL LEAVE

Under the Family and Medical Leave Act of 1993 (FMLA), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- to care for a newly born or adopted child;
- to care for a spouse, parent or child who has a serious health problem;
- if you have a serious health problem that prevents you from performing your job; or
- a qualifying exigency arising out of the fact that the active participant's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty, in support of a contingency operation.

In addition, FMLA may enable you to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member if that individual is your spouse, son/daughter, parent or next of kin, is undergoing treatment or therapy for an illness or injury that occurred in the line of duty, and is an outpatient or on the armed services' temporary disability retired list.

During your leave, you will maintain the coverage you were eligible for at the time of your leave until the end of your leave, as long as your Employer properly grants the leave under the FMLA and makes the required notifications and contributions to the Fund Office on your behalf. The Fund has no role in granting FMLA leave. Your Employer can grant FMLA leave, and your Fund coverage will continue for as long as your Employer continues making the required contributions to maintain your eligibility. If your Employer stops making contributions on your behalf, or if you exhaust your FMLA leave, COBRA Continuation Coverage may become available (see the COBRA section that begins on page 00 for more information about COBRA).

Questions regarding your entitlement to any family and/or medical leave should be referred to your employer. Questions about the continuation of Welfare Fund coverage should be referred to the Fund Administrator.

New York Paid Family Leave

You are also entitled to continue your health coverage while on a New York Paid Family Leave (PFL). During the PFL, you will maintain the coverage you were eligible for at the time you started PFL until the end of your leave, as long as your Employer properly grants the leave under New York PFL and makes the required notifications and contributions to the Fund Office on your behalf.

LEAVE FOR MILITARY SERVICE

If you voluntarily or involuntarily leave your employment position to undertake military service, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994 requires your Employer to grant you unpaid military leave for up to five years and to continue to subsidize your health care coverage for up to 31 days from the first day of your military leave. If your military service exceeds 31 days, you should receive military health care coverage from the U.S. Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Eligible Dependents for a maximum period of 24 months from the first day of your military leave. You must notify the Fund Office at the beginning of your military leave and fill out an election form in order to receive this continuation of coverage.

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). The premium amounts, election periods, and grace periods for USERRA Coverage are the same as COBRA Continuation Coverage. (See the COBRA Continuation Coverage Section for details). However, unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA/USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA. See the COBRA continuation coverage section for details.

Paying for USERRA Coverage. The Participant (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to twenty-four (24) months measured from the date the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be the same as they are for COBRA (102% of the cost of coverage). Payment of USERRA, grace periods and termination of coverage for non-payment of USERRA all work just like with COBRA coverage. See the COBRA section for more details.

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

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

USERRA allows Participants to use their accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA Continuation Coverage. When the Participant/employee's accumulated eligibility is exhausted, the Participant/employee may pay for USERRA coverage under the self-pay rules of the Plan. If the Participant/employee does not want to use their accumulated eligibility to pay for USERRA coverage, they may choose to freeze it and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan as described above.

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

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

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

The Employer must notify the Fund Office in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. If you have any questions about taking a leave of absence, please speak directly with your Employer. If you have any questions about how

a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Reinstatement of Coverage After Leaves of Absence

If your coverage ends while you are on an approved FMLA leave, New York PFL or USERRA military service, your coverage will be reinstated on the day you return to active employment (see the Leave for Military Service section above for more details).

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

COBRA

In General

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the health care coverage provided under this Plan and is available to you and your Eligible Dependents at your own expense provided your coverage is lost due to a "Qualifying Event."

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of qualifying event, a qualified beneficiary can include any Active Participant or Eligible Dependent who is covered by the Plan when a qualifying event occurs. Qualified Beneficiaries have the same rights as an active Participant or Eligible Dependents including special enrollment rights. A child who becomes an Eligible Dependent by birth, adoption, or placement for adoption with the Eligible Participant during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA coverage is not a Qualified Beneficiary.

If you choose COBRA coverage, you and your Dependents have the option to continue the same Medical (including medical and hospital coverage), Prescription Drug, Optical and Dental coverage that you had prior to the Qualifying Event. You can elect a specific type of benefit or all benefit options available to you for COBRA coverage. It does not include Life and Accidental Death and Dismemberment, Short-Term disability, Vacation, or Supplemental Benefits.

If you are eligible for retiree self-pay coverage from the Fund, please be aware that, when you retire, you have the option of electing COBRA continuation of your active coverage instead of retiree self-pay coverage. If you do not elect COBRA continuation coverage when you retire within the timeframes described in the COBRA Election Notice, you will no longer have any rights to COBRA continuation coverage, even when you lose your retiree self-pay coverage. However, if your spouse and/or dependent child(ren) who are covered under the retiree coverage experience a COBRA qualifying event while receiving retiree coverage (for example, if you die or get divorced), they will be entitled to continue the retiree self-pay coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of that coverage.

Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Other Alternatives to COBRA Applicable to Insured Medical Benefits

The following options may be available under New York State insurance law as alternatives to COBRA continuation coverage. These options are only available for the insured Medical benefits. They are not available for prescription drug, dental or optical benefits.

The Right to Elect Continued Coverage under New York State Law. Covered Persons who are not entitled to COBRA continuation coverage may purchase continued coverage as permitted by the New York State Insurance Law up to a total of thirty-six (36) months from the date the federal COBRA should have begun. See the Certificate of Coverage for details on these provisions.

Age 29 Dependent Coverage Extension – Young Adult Option. A dependent Child may elect the *Age 29 Dependent Coverage Extension – Young Adult Option* within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated. See the Certificate of Coverage for details on this provision.

Converting Your Coverage. Under certain circumstances, you can convert your group coverage to individual coverage with comparable benefits or, you can convert your group coverage to a Medicare supplement policy, if appropriate. However, not all your current benefits may be available when you convert your coverage. See the Certificate of Coverage (see *Conversion Right to a New Contract after Termination* in Appendix A) for details on this provision.

COBRA Qualifying Events

To be eligible to elect COBRA coverage, you or your Dependent must ***lose*** coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
Voluntary or involuntary termination of your employment (unless the termination is due to gross misconduct)	Active Participants and Eligible Dependents	18 months*
You lose eligibility due to a reduction in your work hours	Active Participants and Eligible Dependents	18 months
You or your Dependents become disabled at some time before the 60th day of COBRA coverage and the disability lasts until the end of the 18-month COBRA coverage period	Active Participants and Eligible Dependents	Additional 11 months for total of 29 month (or until entitled to Medicare if earlier)
You die	Eligible Dependents	36 months
You become entitled to Medicare (and it causes a loss of coverage for Dependents)	Eligible Dependents	36 months
You become legally separated or divorced from your Spouse	Eligible Spouse and Stepchildren (only step-children will lose coverage upon divorce)	36 months
Your Dependent Child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Eligible Dependent Child	36 months

Availability of COBRA Coverage

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Fund Administrator has been notified that a Qualifying Event has occurred. Your Contributing Employer is responsible for notifying the Fund Administrator of termination of employment, reduction in hours, your death, retirement or entitlement to Medicare, and the Fund Office will determine when the loss of coverage occurs. However, you or your family should also notify the Fund Administrator promptly if any such Qualifying 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 notice.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

Notice of Qualifying Events and Second Qualifying Events

For all other Qualifying Events (as listed below), you must notify the Fund Administrator in writing no later than 60 days after the Qualifying Event occurs. The notice of occurrence of any of these events and all Second Qualifying Events (as described in the section "Multiple Qualifying Events While Covered Under COBRA") must be provided to the Fund Office in writing. Notice may be provided by the Participant or Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Participant or a Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. You must provide the Fund Office notice of the following Qualifying/Second Qualifying Events:

1. When a Participant divorces or legally separates from his or her Spouse, notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the Qualifying Event. A copy of the court document must be included with the notice.
2. When a child ceases to be covered under the Plan as a Dependent Child of an eligible Participant, notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the Qualifying Event.
3. When the eligible Participant becomes eligible for Medicare and such eligibility would cause a loss of coverage for Dependents.
4. When a Qualified Beneficiary experiences a Second Qualifying Event.
5. When a Qualified Beneficiary is determined by the Social Security Administration to be disabled during a COBRA coverage period or when the Social Security Administration determines that a Qualified Beneficiary is no longer disabled. See the section entitled, "COBRA Coverage for Disabled Eligible Participants" for details.

Failure to provide this notice in the form and within the timeframe described above may prevent you and/or your Eligible Dependents from obtaining or extending the COBRA coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

How COBRA Continuation Coverage is Provided

When the Plan Administrator is notified that a Qualifying Event has occurred, the Plan Administrator will then provide you and/or your Eligible Dependents with notice of the date on which your coverage will end, and the information and election form that you will need in order to elect COBRA coverage. Under the law, you and/or your Eligible Dependents will then have only ***60 days*** from the later of the date you ordinarily would have lost coverage because of the Qualifying Events, or the date you and/or your Eligible Dependents received the notice, to apply for COBRA coverage.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN **60 DAYS** AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA coverage. COBRA coverage may be elected for some members of the family and not others. In addition, one or more Eligible Dependents may elect COBRA even if the Eligible Participant does not elect it. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the Qualifying Event or became an Eligible Dependent by birth, adoption, or placement for adoption during the period of COBRA coverage. An Eligible Participant may elect COBRA coverage on behalf of his or her Spouse and a parent may elect or reject COBRA coverage on behalf of Dependent Children living with him or her.

Payment for COBRA Coverage

You are responsible for the entire cost of COBRA coverage and can pay for the coverage on a monthly basis. When you and/or your Eligible Dependents become entitled to this coverage, the Plan Administrator will notify you of the COBRA premium amounts that you must pay. Covered Persons who continue full coverage under COBRA pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Coverage for Disabled Eligible Participants").

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Fund Office not later than ***45 days*** after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within 45 days after the date of your election, your continuation coverage rights under the Plan will not take effect.

Payments for subsequent months are due on the first day of the month for which coverage is provided. You will NOT be sent any bills or reminders for subsequent months. It is your responsibility to make payment by the first of the month. If you do not remit your payment by the due date or within the grace period for that payment, your COBRA coverage will end.

Grace Period for Payments

Although payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

COBRA Coverage for Disabled Eligible Participants

If, during an 18-month COBRA coverage period the Social Security Administration determines that you (or a member of your family who is eligible for COBRA coverage) were disabled at some time before the 60th day of COBRA coverage, the disabled person and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA coverage, for a total maximum of 29 months. **You must notify the Plan Administrator of the determination of your disability in writing within 60 days of the date of that determination and before the end of the 18-month period of COBRA coverage**. The notice of disability must be in writing. If the 18-month period of COBRA Coverage is extended because of Social Security disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

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

- The last day of the month, 30 days after Social Security has determined that you and/or your Eligible Dependent(s) are no longer disabled;

- The end of the 29 months of COBRA coverage;

- The date the disabled person becomes entitled to Medicare.

You must notify the Fund Administrator in writing within 30 days of a final Social Security determination that you are no longer disabled.

Multiple Qualifying Events While Covered Under COBRA

If, during an 18-month period of COBRA coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A or B or both), or if an Eligible Dependent Child ceases to be an Eligible Dependent under the Plan, the maximum COBRA continuation period for the affected Spouse and/or child(ren) is extended to 36 months from the date of your termination of employment or reduction in hours.

In no case are you (the Active Participant) entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA coverage may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event.

If your family experiences a Second Qualifying Event, you must notify the Fund Office of the Second Qualifying Event within 60 days of the event according to the procedures described in the section " Notice of Qualifying Events and Second Qualifying Events."

In no event is anyone else entitled to COBRA coverage for more than a total of 36 months.

Termination/Reduction in Hours That Follows Medicare Entitlement

If you become entitled to Medicare and you later have a termination of employment or reduction in hours, your Eligible Dependents who are Qualified Beneficiaries would be entitled to COBRA coverage for a period of: (a) 18 months (29 months if the 11-month Social Security disability extension applies) from your termination of employment or reduction in hours; or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

Early Termination of COBRA Coverage

COBRA coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The first date of the time period for which you do not pay the COBRA premiums within the required timeframe after electing COBRA.

- The date, after the date of the COBRA election, in which you or your eligible dependent(s) first become covered by another group health Plan.

- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65);

- The date the Plan terminates its group health plan and no longer provides group health insurance coverage to its members;

- The date the Employer that employed you prior to the Qualifying Event has stopped contributing to the Plan; and (1) the Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered under this Plan; or (2) the Employer starts contributing to another multiemployer plan that is a group health plan; or

- If coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled, the date you are no longer disabled.

Notice of Early Termination of COBRA Coverage

The Plan Administrator will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the Qualified Beneficiary(ies) 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(ies) 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.

Coverage Options for Insured Medical Benefits once COBRA Continuation is Exhausted

The following options may be available under New York State Insurance Law upon the exhaustion of COBRA continuation coverage. These options are only available of the insured Medical benefits. They are not available for prescription drug, dental or optical benefits.

The Right to Elect Additional Continued Coverage under New York State Law When Continued Coverage under Federal Law Ends. Covered Persons who have exhausted their 18-month period under COBRA Continuation Coverage may purchase additional continued coverage as permitted by the New York State Insurance Law up to a total of thirty-six (36) months from the date continued coverage under federal COBRA began. Note: This right to elect additional continued coverage does not apply to covered individuals who elect to continue coverage through age twenty-nine (29) under the New York Young Adult Option. See the Certificate of Coverage for details on these provisions.

Converting Your Coverage. Under certain circumstances after you have exhausted your COBRA continuation coverage (or state continuation), you can convert your group coverage to individual coverage with comparable benefits or, you can convert your group coverage to a Medicare supplement policy, if appropriate. However, not all your current benefits may be available when you convert your coverage. See the Certificate of Coverage (see Conversion Right to a New Contract after Termination in Appendix A) for details on this provision.

Age 29 Dependent Coverage Extension – Young Adult Option. A Child may be eligible to purchase continuation coverage under the Plan's group contract through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s). The Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the notice and premium payments are received; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when notice of election and premium payment are received.

The Premium rate is the one that applies to individual coverage. Coverage will be the same as the coverage provided under the Certificate of Coverage. The Child's children are not eligible for coverage under this option.

COBRA Questions or To Give Notice of Changes in Your Circumstances

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Plan Informed

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

Plan Contact Information

Derrickmen's Welfare Fund, Local 197
Daniel H. Cook Associates Inc.
253 West 35th Street, 12th Floor
New York, NY 10001
(212) 505-5050

MEDICAL COVERAGE

HOSPITAL, MEDICAL AND PRESCRIPTION DRUG BENEFITS

The Derrickmen's Welfare Fund, Local 197, provides you and your covered Dependents with medical (hospital), and prescription drug coverage through an insurance contract. The details about these benefits, including what is covered and exclusions and limitations, are included in the coverage description prepared by the insurance company and attached to the end of this document as the Appendix.

If there is a difference between the information contained in this booklet and the Certificate issued by the insurance company, the terms of the Certificate will govern.

Women's Health and Cancer Rights Act (WHCRA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Addiction Equity Act (MHPAEA) and Claims and Appeals and Patient Protection Rights of the Affordable Care Act (ACA)

This Plan complies with all state and federal laws and regulations including the Women's Health and Cancer Rights Act (WHCRA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA) regulations and the Affordable Care Act (ACA) including Patient Protection Rights and Claims and Appeals Rights. See the Certificate of Coverage from the Medical Insurer for details on these provisions.

Your Certificate of Coverage (Certificate) gives you the most details about your health care coverage. It is the legal description of your coverage. Some of the language that specifically details your benefit coverage levels that is included in your Certificate is included in this booklet. However, you should rely on the Certificate for the most detail about your benefit levels.

Empire Healthchoice Assurance, Inc.
Prism Exclusive Provider Organization (EPO) Schedule Of Benefits

This Schedule of Benefits adds specific details relating to cost share requirements and other benefit conditions relating to your coverage described in the Certificate of Coverage which is attached (see Appendix A)

Medical Management Penalty for failure to precertify Covered Services for each service requiring precertification and all inpatient admissions, including professional services	50% up to $5,000
Lifetime Benefit Maximum	Unlimited

COST-SHARING AMOUNTS	IN-NETWORK
Annual Deductible	
Individual	Not applicable
Family	Not applicable
Coinsurance (Member responsibility)	Not applicable
Annual Out-of-Pocket Limit**	
Individual	$4,400
Family	$11,000
Cost-Sharing Maximum Calculation Period	Calendar Year
Benefit Day/Visit Maximum Calculation Period	Calendar Year
OFFICE VISITS	
Visits to a Provider in the Provider's office, Covered Person's home or outpatient department of a Hospital. Primary Care Copayment: For visits to the following Providers: Patient's PCP, including family practitioners, general practitioners, internists, pediatricians, geriatricians; obstetricians, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists, unless otherwise stated in this Schedule of Benefits.	
Child (birth to age 26)	$25
Adult (age 26 and older)	$25
Specialist/Outpatient Facility Copayment For visits to all other specialists, and for services provided by an outpatient department of a Hospital, unless otherwise stated in this Schedule of Benefits.	
Child (birth to age 26)	$25
Adult (age 26 and older)	$25
OUTPATIENT MEDICAL THERAPIES	
Physical Therapy	Office Visit Copayment
Visit maximum, any combination – home, office, outpatient department	30
Occupational, Speech, Vision Therapies	Office Visit Copayment
Combined visit maximum, any combination – home, office, outpatient department	30
Chiropractic Care	Office Visit Copayment
Acupuncture	$25 (Office Visit Copayment)
Dialysis	$0
Chemotherapy	$0
Radiation Therapy	$0
Cardiac Rehabilitation	Office Visit Copayment
Allergy Care	
Office Visit Exams, Evaluations, Consultations	Office Visit Copayment
Testing	$0
Allergy Injections/Immunotherapy	$0
Home Health Care	$0
Visit maximum (4 hours of care equals 1 visit)	100
Applied Behavior Analysis Up to 680 hours per Member per year	Primary Care Office Visit Copayment

COST-SHARING AMOUNTS	IN-NETWORK
OUTPATIENT SERVICES	
Surgical Procedures performed in the Office	
Primary Care	$0
Specialist	$0
Medical Supplies	$0
Durable Medical Equipment	50% Coinsurance
Prosthetics	50% Coinsurance
Orthotic Appliances	50% Coinsurance
Diagnostic Radiology Services	$0
MRIs, MRAs, PET Scans, CAT Scans and Nuclear Cardiology Scans	$50
Laboratory Services	$0
Ambulatory Surgery Center and Outpatient Procedure Services	$100
Presurgical Testing (performed within 7 days of scheduled surgery)	$0
Urgent Care	Specialist Office Visit Copayment
Ambulance Services (land and air)	$0
Emergency Room	$100 (waived if admitted within 24 hours)
INPATIENT ADMISSIONS	
Inpatient Hospital	$200
Annual Copayment Out-of-Pocket Maximum	$500
Inpatient Hospital Physical Rehabilitation	Same as Inpatient Hospital
Day maximum	30
Skilled Nursing Facility	$200 copayment per admission up to $500 maximum/benefit period 60 day maximum
Annual Copayment Out-of-Pocket Maximum	$250
Day maximum	60
HOSPICE CARE	
Day maximum	Unlimited
Inpatient	$0
At Home	$0
PREVENTIVE CARE	
Well-Child Care (up to age 19) - Newborn baby- 1 in-Hospital exam at birth - Birth up to 1st birthday: 7 visits - Ages 1 through 4 years of age: 7 visits - Ages 5 through 11 years of age: 7 visits - Ages 12 through 17 years of age: 6 visits - Ages 18 to 19th birthday: 2 visits	$0
Annual Adult Physical Exam (age 19 and older)	$0
Preventive Well-Woman Care	$0
Covered Preventive Screening Tests	$0
MATERNITY CARE	
Maternity Office Visits (prenatal and postnatal care)	$0
Inpatient (for delivery)	Same as Inpatient Hospital
Routine Newborn Nursery Care (in Hospital)	Same as Inpatient Hospital
MENTAL HEALTH CARE	
Outpatient Treatment	
Performed in a PCP or Specialist Office or home	$25
Performed as Outpatient Hospital Services	$0
Visit maximum, any combination – home, office, outpatient department	Unlimited
Inpatient	Same as Inpatient Hospital
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited
ALCOHOL/SUBSTANCE ABUSE TREATMENT	
Outpatient	
Performed in a PCP or Specialist Office or home	$25
Performed as Outpatient Hospital Services	$0
Visit maximum, any combination – home, office, outpatient department	Unlimited
Inpatient Detoxification	Same as Inpatient Hospital

Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited
Inpatient Rehabilitation	Same as Inpatient Hospital
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited

ONLINE VISITS SCHEDULE OF BENEFITS

SERVICE	IN-NETWORK	OUT-OF-NETWORK
Online Visits	Member cost share same as Primary Care Office Visit	Not Covered

*Exclusions. See Certificate of Coverage for exclusions and limitations under the Plan.
**See Prescription Drug Benefit for prescription drug out-of-pocket maximum.

Exclusions and Limitations to Medical Benefits

This is a summary of coverage exclusions and limitations for a full list, please see the Certificate of Coverage for exclusions and limitations under the Plan. No coverage is available under this Certificate for the following:

A. Aviation. We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care. We do not Cover services related to rest cures, custodial care or transportation. “Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy. We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services. We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

G. Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for noninvestigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation. We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care. We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility. We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

K. Medically Necessary. In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program. We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

M. Military Service. We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance. We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed. We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member. We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees. We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge. We do not Cover services for which no charge is normally made.

S. Vision Services. We do not Cover the examination or fitting of eyeglasses or contact lenses.

T. War. We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.
U. Workers' Compensation. We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

PRESCRIPTION DRUG COVERAGE

The Prescription Drug Benefit is designed to help you pay for your prescription drug needs and is self-funded. The Fund has contracted with General Prescription Plans (GPP) to administer the program on its behalf. In addition to paying claims, the Fund also pays GPP an administrative fee. You can find their contact information in the *Contact Chart* at the front of this document.

How the Prescription Drug Plan Works

There are two different ways for you to obtain a prescription medication (which are described in this section):

- From Participating Retail Pharmacies using a prescription drug card; and
- By Mail Order.

Copayments and Annual Out-of-Pocket Maximum

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them. You will be required to pay a copayment when you receive a prescription. The copayment is a set dollar amount you pay for the prescription while the Plan pays the rest (or most of the rest) of the cost of that prescription. Once you reach the out-of-pocket limit for prescription drugs received from participating pharmacies during the calendar year, the Plan will pay 100% of your prescription drugs for the remainder of the calendar year (until December 31st). If you have other family members covered under this Plan, they have to meet their own out-of-pocket limits until the overall family limit has been met.

Summary of Prescription Drug Benefit Copayments		
Medication Type	**Prescriptions from a Participating Retail Pharmacy**	**Prescription from a Mail Order Pharmacy**
Generic Medications	$10	$20
Brand Name Medications	$20	$40
ACA Required Preventive Medications	$0	$0
Note that maintenance-type medications can be filled up to a maximum of three times at a participating retail pharmacy, then they must be submitted through the mail order program described below.		
Supply of Medication	30-days per prescription or refill	31-90-days per prescription or refill
Annual Out-of-Pocket Maximum Prescription drugs do not count towards the Out-of-Pocket Maximums for Medical and vice versa.	Prescription drug Out-of-Pocket Maximum is $2,200/Individual and $4,400/Family. This amount is adjusted annually in accordance with applicable guidance.	

Retail Pharmacy Benefits - Participating Pharmacy

GPP has arrangements with Pharmacies that have agreed to accept the Plan's payment (less applicable copayment) as payment in full. These are called participating Pharmacies. You will be provided with a Pharmacy Card that you can use at any participating pharmacy to purchase prescription drugs. A complete listing of participating pharmacies is available from the Fund Office. You can also get a list of participating pharmacies by calling GPP (contact information can be found in the *Contact Chart* in the front of this booklet). When you present this card to the pharmacist, you will receive a 30-day supply of your medication. By presenting your card, you will pay your applicable copay and the Plan pays the rest.

No coverage is available for non-participating pharmacies. If you use a non-participating pharmacy, you will be responsible for the entire cost of the prescription.

Mail Order Pharmacy

Mail service offers a convenient and less expensive way to fill prescriptions for medications you take for an extended period. You can receive up to a 90-day supply plus refills of maintenance-type medications to treat chronic or long-term conditions (like arthritis, high blood pressure, or diabetes) when you use the mail order service through GPP mail order pharmacy.

Prescriptions will generally be prescribed electronically and sent directly to GPP. However, if your provider gives you a prescription for a maintenance type drug, ask him to write a prescription for a 90-day supply, plus one, two or three refills. Next, write your member ID number and group number on the back of each original prescription and mail your prescriptions(s) with the completed form in the pre-addressed postage-paid envelope provided. Forms and envelopes can be obtained from GPP. Your prescription order will be delivered postage-paid directly to your home. If you have any questions or problems regarding your prescription order, or if you do not receive your medication [within 14 days], contact GPP.

Note that maintenance-type medications can be filled up to a maximum of three times at a participating retail pharmacy, then they must be submitted through the mail order program described above.

Limits

Prescription drug coverage is limited to a 30-day supply per prescription for non-maintenance drugs; maintenance medications are limited to a 90-day supply.

Covered Drugs and Supplies

- Established Federal Legend Drugs: A prescription legend drug is any medical substance required to bear the label “Caution: federal law prohibits dispensing without a prescription.”

- Compound Medications: Pharmacist mixed-to-order medication that contains at least one eligible medicinal substance (an established federal legend drug).

- Insulin and Insulin Disposable Syringes/Needles: This Plan covers insulin (a non-legend drug) and insulin disposable syringes and needles.

Preventive medications

The Plan covers the following ACA generic preventive medications, including generic contraceptives (or brand name if a generic is medically inappropriate), at no cost to you. Coverage of preventive medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider.

- Aspirin to prevent cardiovascular disease when prescribed by a health care Provider. A prescription must be submitted in accordance with Plan rules.

- 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.

- Oral Fluoride supplements at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.

- 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.

- Iron supplements are covered for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Over-the-counter supplements are covered only with a prescription.

- 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.

- Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices.

- All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen 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. Over-the-counter medications are covered only with a prescription.

- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements 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 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, when identified as meeting these factors by their treating physician.

For the most up-to-date list of covered medications (including those specific medications covered as preventive under the ACA), contact GPP for information.

Drugs and Supplies Excluded from Coverage

- This Plan does not cover drugs that require a prescription by state law but not federal law.

- Experimental drugs or drugs labeled "Caution: Limited by federal law to investigational use," except as required by the Affordable Care Act.

- Prescriptions that an eligible person may be covered for, with or without charge, under any Workers' Compensation law or third-party liability, or through a government entity (except for non–military service–connected care in a Veterans Administration Facility).

- Non-legend drugs (those that do not require a prescription) or over-the-counter drugs (except required preventative drugs under the ACA for which you present a prescription).

- Dispensed amounts in excess of the amount specified by the physician or in excess of Plan limits.

- Prescriptions filled or refilled after one year from the date of the original prescription.

- Medications taken by, or administered to, an individual while a patient in a licensed hospital, nursing home or similar institution that operates, or allows operation on its premises of a facility for dispensing pharmaceuticals.

- Non-medicinal medical supplies and equipment, including therapeutic devices or appliances such as hypodermic needles and syringes (except to administer insulin), support garments and other non-medical substances, except as required by the Affordable Care Act.

- Immunization agents, vaccines, allergy extracts, biological sera, blood or blood plasma, except as required by the Affordable Care Act.

- Treatments, drugs or shampoos used for alopecia or scalp problems.
- Oral fluoride rinses.
- Dietary aids and food supplements.
- Fertility drugs.
- Prenatal vitamins or children's vitamins in excess of a 30-day supply, except as required by the Affordable Care Act.
- Human growth hormones.
- Cosmetic products such as Tretinoin, Retin-A (or any other product invented for the same use as Retin-A).

The Board of Trustees will review this list from time to time, in light of new drugs approved by the FDA, and other considerations, and re-issue the list of covered and non-covered drugs.

Prescription Drug Benefits for Medicare Eligible Participants

Medicare covers prescription drug benefits under Part D. If you, as an Active Participant, and/or your Eligible Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D. For Active Participants and their Eligible Dependents 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 Participant 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 (October 7 – December 15 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 calling the Fund Office and asking for one.

RETIREE BENEFITS

SELF-PAY RETIREE COVERAGE

Eligibility

If you are a retired member receiving a Pension from the Derrickmen's Pension Fund, Local 197, and you earned at least five years of Vesting Service as defined under the Derrickmen's Pension Fund, Local 197, you and your spouse will be eligible to receive health coverage through the Fund on a self-pay basis. Please note that this self-pay provision is offered as an alternative to COBRA coverage. Therefore, at retirement, you will be offered the option of electing to continue coverage under the self-pay provision described in this section or under the "COBRA Continuation of Coverage" section.

Required Payments by Retiree or Family Member

If you elect the self-payment coverage, you must complete the Election/Rejection Form and send it along with a check covering the cost of coverage to the Derrickmen's Welfare Fund, Local 197. **You must send these items by the tenth day of the month you wish to commence coverage or you will lose your right to receive this coverage.** The second check, and subsequent payments must also be sent by the tenth of every month for your coverage to continue. If you fail to make the monthly payment due, your coverage will terminate at the end of the period for which payment has been made, and coverage cannot be reinstated. You will not receive a bill from the Fund. Therefore, you must remember to send the premium on your own initiative. You can, if you prefer, pay the premium on a quarterly, semi-annual, or annual basis, in advance.

Please note that no claims will be paid until we receive your payment, so please act promptly if you wish to continue coverage.

The premium rates are subject to change, in the event that the cost to the Fund of providing the coverage changes in the future. You will be notified of any change in the rates. If the employee does not choose the self-pay coverage for himself, his spouse, and/or his child(ren), covered dependents can still elect this self-pay coverage independently.

YOU SHOULD RESPOND IMMEDIATELY SO YOU WILL ASSURE CONTINUITY OF COVERAGE AND AVOID POSSIBLE CLAIM DENIAL IF COVERAGE IS CANCELED WHILE YOU DECIDE. NO CLAIM INCURRED DURING THIS ELECTION PERIOD WILL BE PAID UNLESS YOU ELECT THIS COVERAGE ON A TIMELY BASIS.

Duration of self-pay coverage

If you make the monthly payments, as indicated, above, your health-related benefit coverage will be continued **until you become eligible for Medicare**. Once you are eligible for Medicare (either because of age or disability), you can no longer receive the self-pay coverage, but your spouse, if he or she is still not eligible for Medicare, and your covered dependent children (who are not Medicare eligible), can elect to continue on the self-pay coverage. At the time you become Medicare eligible, the Fund Administrator will forward the necessary election forms to your dependents. Please note, you must notify the Fund when you become eligible for Medicare and "re-enroll" your dependents.

DENTAL EXPENSE BENEFITS

BENEFITS PROVIDED

The Welfare Fund provides comprehensive dental benefits on a self-insured basis. Benefits are paid according to a schedule of benefits, as approved and modified periodically by the Trustees of the Fund. You may go to any dentist you wish. However, you are responsible for any difference between the schedule amount and the actual amount charged by the dentist. The dental schedule of benefits is a separate document that you should keep with this booklet. Please contact the Fund Office if you would like to request another copy.

Dental Benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) because they are separately elected and administered.

Maximum Benefit

The maximum dental benefit available to each family is $2,000 per family per benefit year. A benefit year begins on February 1st and ends on the following January 31st. The implant benefit is a maximum of $2,000 per tooth with a lifetime maximum of $4,000.

Benefits Following Termination of Insurance

Payment for dental benefits will be made only for treatment rendered during the time that you and your dependents are eligible for Welfare Fund benefits. (See the "Eligibility" section of this booklet to determine your eligibility.)

Expenses Not Covered

No Payment will be made for expenses incurred:

1. As a result of an occupational accident or sickness covered by workers' compensation;

2. For treatment services or supplies received in or from a hospital owned or operated by the United States government or through any public program;

3. For treatment received prior to the effective date of this Plan or after this Plan is cancelled;

4. For orthodontic services in excess of a lifetime maximum of $2,300.

5. That are in excess of the maximum allowances for dental services.

Claim Forms

Contact the Fund Administrator to obtain a claim form. Claim forms must be completed by your dentist and returned to the Fund Administrator. You may also use the ADA 2000 form provided by your dentist's Office. Claims should be filed with the Fund Office.

OPTICAL BENEFITS

BENEFITS PROVIDED

Optical Benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) because they are separately administered by Vision World and GVS.

You and your dependents are each entitled to receive optical benefits every 12 months at any Vision World/GVS participating optical centers listed on the reverse side of your optical voucher. If you use any of the optical centers, there will be no out-of-pocket cost to you or your dependents, except for any of the extras listed below. Under the Vision World/GVS optical plan, participants and their dependents are each eligible to receive two $175 vouchers every 12 months.

You can use your optical voucher to receive the following benefits:

- a comprehensive eye exam;
- contact lenses fitting fee and follow-up visits;
- selection of a choice of frames up to a retail value of $80 ($160 for employee-participants);
- selection of a choice of any prescription plastic lenses including single vision, bifocals, trifocals, safety and oversize;
- cosmetic tinting and sunglass tints on prescription lenses;
- standard sight daily wear spherical contact lenses and extended wear contact lenses (for employee-participants ONLY). Basic spherical disposable contact lenses will be covered for the first three month supply (2 boxes) (for employee-participants only). Unlimited follow-up visits for one year.

Lasik Eye Surgery

The Fund provides a benefit for Lasik vision correction surgery up to a maximum of $3,000 per eye per lifetime. This benefit is available only to Participants; Dependents are not eligible for this benefit. In order to be eligible for this benefit, you must accumulate at least 1,500 hours in the twelve previous consecutive months.

How it Works

You may go to any provider you choose for this surgery. In order to receive the benefit, all you need to do is ask your provider to contact the Fund Office to verify your eligibility for coverage and payment. The provider will then invoice the Fund directly and will be paid up to the maximum allowed benefit. If the cost of the procedure exceeds the maximum benefit of $3,000 per eye per lifetime, you will be responsible for the difference between what the Fund pays and what the provider charges.

Please note that the Lasik vision corrective surgery is in lieu of future reimbursement for contact lenses and/or glasses. This means that once you receive the Lasik vision corrective surgery, you will no longer be eligible for contact lenses and/or glasses in future years.

BENEFIT EXCLUSIONS

The Vision World/GVS optical benefit does not cover expenses for colored contact lenses.

Benefit Limitations – Employee-Participants

If you choose an upgraded frame outside the Vision World collection, with the exception of special promotion or sale frames, employee-participants will receive reimbursement up to $130.00. For non-covered contact lenses (excluding colored and disposables), employee-participants will receive reimbursement up to $80.00 towards any amount purchased.

Limitations – Dependents

If your dependent chooses an upgraded frame outside the Vision World collection, with the exception of special promotion or sale frames, your dependent(s) will receive reimbursement up to $80.00. For non-covered contact lenses (excluding colored and disposables) your dependent(s) will receive reimbursement up to $40.00 towards any amount purchased.

Vision World Special Discount Program

Vision World will provide a 30% discount off a complete second pair of eyeglasses. Contacts as a second pair or additional contact lenses will be offered at a 30% discount as well. (The 30% discount off contacts as a second pair does not include fitting fee and discount only applies to purchase at time of benefit). Vision World will also offer a discount of $5.00 off the eye examination fee to the family of members not covered by the programs, to any member wanting an additional pair of glasses or for members and dependents seeking an additional exam during their 12 month benefit period.

If eyeglasses are prescribed, the covered individual is entitled to:

- Any single vision lenses (glass, plastics, oversized or tinted);
- Any bifocal or trifocal lenses (glass, plastics, oversized or tinted); and
- A choice of selected frames in any of the optical centers

The only extra cost to the patients would be for:

- Photosensitive bifocals ($20);
- Invisible bifocals ($20);
- Cataract lenses - in accordance with American Optical Wholesale prices; or
- Examinations in states whose law precludes the examination fee being a part of the optical package.

Applying For Benefits

It is important that you contact the Fund Administrator and request a voucher for optical services before you go to the optical center. The Fund Administrator will ask you to furnish the name of the person to receive the benefit.

After you receive the voucher, sign your name on the appropriate line. It is then ready for use. The reverse side of the voucher lists the locations of the optical centers. If you have questions about your optical benefits, contact the Fund Administrator or Vision World at 1-800-VISION-1.

COORDINATION OF BENEFITS: DENTAL, PRESCRIPTION DRUG AND OPTICAL BENEFITS

This section applies to the prescription drugs, dental, and optical claims. Coordination of Benefits (COB) provisions for insured medical (medical/hospital) benefits are described in the attached Certificate of Coverage.

How Duplicate Coverage Occurs

Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, you must let the Fund Administrator (or its insurer) know about all your coverages when you submit a claim.

This section describes the circumstances when you or your covered dependents may be entitled to benefits under this Plan and may be entitled to recover all or part of covered expenses from some other source**.** In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits.

This section describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover any amount from some other source.

Coverage Under More Than One Group Health Plan

When and How Coordination of Benefits (COB) Applies. For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the covered individual or that provides medical or dental services to the covered individual. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage.

Which Plan Pays First: Order of Benefit Determination Rules

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

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

Rule 1: Non-Dependent/Dependent

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

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering

the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

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

   1. the parents are married;

   2. the parents are not separated (whether or not they ever have been married); or

   3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

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

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

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

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

   1. The plan of the custodial parent pays first;

   2. The plan of the spouse of the custodial parent pays second;

   3. The plan of the non-custodial parent pays third; and

   4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

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

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

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

Rule 4: Continuation Coverage

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

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

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

Rule 5: Longer/Shorter Length of Coverage

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

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

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

1. in the amount or scope of a plan's benefits;

2. in the entity that pays, provides or administers the plan; or

3. from one type of plan to another (such as from a single-employer plan to a multiple-employer plan).

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

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay 100% of "Allowable Expenses" less whatever payments were actually made by the plan(s) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first. The Claims Administrator will review the explanation of benefits (EOB) from the primary plan to determine how much the primary plan paid, then it will pay up to the allowed amount payable by the Plan. "Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- If the coordinating plans determine benefits on the basis of Usual, Customary, and Reasonable (UCR) Charges, any amount in excess of the highest UCR Charge is not an Allowable Expense.

- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

- If one coordinating plan determines benefits on the basis of UCR Charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment

arrangement is the only Allowable Expense for all plans. In determining whether you will be entitled to any payment from the secondary plan, you must understand whether the plan provides benefits on a negotiated fee basis (like most In-Network benefits) or on the basis of UCR Charges (like most Out-of-Network benefits).

- When benefits are reduced by a primary plan because a covered Individual did not comply with the primary plan's provisions, such as the provisions related to utilization management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.

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

Administration of COB

1. To administer coordination of benefits, the Plan reserves the right to:

    - exchange information with other plans involved in paying claims;
    - require that you or your health care provider furnish any necessary information;
    - reimburse any plan that made payments this Plan should have made; or
    - recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.

2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Fund Administrator determines to be proper. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply the coordination of benefits rules.

4. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

5. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to coordination of benefits, but only to the extent they would have been payable if this Plan were the primary plan.

6. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the participant or dependent may have against the other plan, and the participant or dependent must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination with Medical Medicare.

See the Certificate of Coverage for details on how this Plan coordinates with Medicare.

Coordination With Other Government Programs

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

B. ***TRICARE****:* If a covered dependent is covered by both this Plan and the TRICARE/Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), the program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE/CHAMPUS pays second. For an employee called to active duty for more than 30 days, TRICARE is primary and this Plan is secondary.

C. ***Veterans Affairs Facility Services****:* If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Usual, Customary, and Reasonable.

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

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

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

Workers' Compensation

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

Consult the insurance company's Certificate of Coverage for details about coordination of benefits for hospital, medical and prescription drug benefits.

TERM LIFE INSURANCE BENEFIT

The life insurance benefit is insured and administered by The Union Labor Life Insurance Company (Union Labor Life).

If you are eligible to receive and are in receipt of a pension from the Derrickmen's Pension Fund, Local 197, and you earned at least five years of Vesting Service as defined under the Derrickmen's Pension Fund, Local 197, you are considered a retired employee of the Plan and are eligible for life insurance benefits provided by the Fund (not Union Labor Life).

Overview of Life Insurance Coverage

If you die from any cause while you are covered under the Plan, the proceeds of this benefit will be paid to your beneficiary after the receipt of complete proof of death. The amount of your life insurance benefit is $25,000 if you are working. If you are an eligible retired employee as described above, the amount of your life insurance benefit is $15,000.

A certified copy of the death certificate would be considered proof of death, along with any other data that Union Labor Life or the Fund may require to establish the claim's validity.

Naming a Beneficiary

You may name anyone you wish as your beneficiary for this benefit. Simply enter that person's name in the appropriate space on your beneficiary enrollment form when you first enroll in the Plan. You may name more than one beneficiary to receive the life insurance benefit. You can change your beneficiary or beneficiaries at any time without the consent of the previously named beneficiary. Any changes you make must be made in writing by filling out a new beneficiary enrollment form. The beneficiary or beneficiaries on file with the Fund Administrator at the time of your death is the person or are the persons who will receive the proceeds of your life insurance benefit, no matter what may be specified in your will. It is important that you name a beneficiary and keep your beneficiary enrollment form up-to-date. On receipt of proof of a claim, Union Labor Life (or the Fund Administrator, as applicable for retired employees) will pay the death benefit due under the policy to your named beneficiary. If you named more than one beneficiary, each will share equally, unless you indicated otherwise when you named your beneficiary.

If you have not designated a beneficiary or if your beneficiary dies before you, your life insurance benefit will be paid to the first surviving person or persons, as follows: your surviving spouse; your children, in equal shares; your parents, in equal shares; and then your brothers and sisters, in equal shares. If payment cannot be made to any of the indicated individuals, your life insurance benefit will be paid to the executors or administrators of your estate. In order to determine who is entitled to the benefit, Union Labor Life (or the Fund Administrator, as applicable for retired employees) will rely on an affidavit made by any of the aforementioned individuals. Union Labor Life (or the Fund Administrator, as applicable for retired employees) will be reasonably discharged of its liability for the amount paid based on the affidavit unless written notice of claim by another individual is received before payment is made.

If any beneficiary is a minor, or someone not able to give a valid release for payment, payment will be made to his or her legal guardian. If there is no legal guardian, payment will be made to a person(s) or institution that has, in Union Labor Life's (or the Fund Administrator, as applicable for retired employees) opinion, custody and principal support of that beneficiary.

Payment of Your Life Insurance Benefit

The life insurance benefit will be payable in a lump sum. There may be optional plans for payment available; details of which are available upon request from Union Labor Life.

Facility of Payment

If an individual appears to Union Labor Life (or the Fund Administrator, as applicable for retired employees) to be equitably entitled to compensation because he or she has incurred expenses on behalf of the participant's burial, Union Labor Life (or the Fund Administrator, as applicable for retired employees) may pay to such individual the expenses up to $500. Such payment, however, shall not exceed the amount due under Union Labor Life's policy or the Fund's plan of benefits, as applicable. Union Labor Life (and the Fund, as applicable) will be fully discharged of its liability for any amount of benefit paid in good faith.

Additional Information regarding Insured Life Insurance Benefit

See your Certificate of Insurance from The Union Labor Life Insurance Company for information or details regarding:

- Continuation During Total Disability;
- Waiver of Premium Possibility in Conversion of Life Insurance;
- Death of Person While the Waiver-of-Premium Extension is in Effect; and
- Conversion Privilege.

Termination of Insured Life Insurance Benefit

Your life insurance benefit insured by Union Labor Life will terminate upon the earliest of:

1. the date the Fund's policy terminates;
2. the date you are no longer in a class of eligible persons under the policy;
3. the date premium payments on behalf of you cease;
4. the date you fail to pay the required premium, if any, when due; or
5. the month following the period of 12 consecutive months during which you did not work the required 600 hours.

How to File a Claim or Appeal

For more information on how to file a life insurance benefit claim, and how to appeal a denied (whether in whole or part) claim, see "Claims and Appeals Procedures" section.

NOTE: This is not a complete benefit comparison or a contract, and should only be viewed as a summary to assist you in understanding your life insurance and AD&D benefits. You will also receive an individual certificate of insurance that summarizes your benefits. However, the terms, conditions, limits and exclusions are outlined in the policy and if there is any difference between the provisions of the Certificate and/or this description and the policy, the provisions of the policy will govern.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Your Accidental Death and Dismemberment (AD&D) benefit is insured and administered by The Union Labor Life Insurance Company (Union Labor Life).

Overview of AD&D Coverage

An accidental dismemberment benefit is paid to you, or an accidental death benefit is paid to your beneficiary if you have a covered loss due solely to an accident. A covered loss is a permanent loss of life, loss of one or more body parts, or loss of sight, as described below in the Schedule of Losses. In order for benefits to be payable, you must suffer the loss while insured and the covered loss must occur within 90 days after the date of the accident. These benefits are in addition to any other benefits you may receive.

Receipt of Your AD&D Benefit

If you have an accident that results in a dismemberment to you, you will receive an accidental dismemberment benefit. If you have an accident that results in your death, your beneficiary will receive an accidental death benefit.

Naming Your Beneficiary

You may name anyone you wish as your beneficiary by filing the appropriate form with the Fund Administrator. The beneficiary on file with the Fund Administrator at the time of your death is the one who will receive the accidental death benefit, no matter what is specified in your will. For further information regarding naming your beneficiary, see the procedures for naming your beneficiary under the "Life Insurance Benefit" section of this document.

The Amount of Your Accidental Death and Dismemberment Benefit

The amount of benefit paid for a covered loss is as follows:

Schedule of Losses

For Loss Of:	The Benefit Is:	Payable To
Life	$25,000	Your Beneficiary
Two Hands	$25,000	You
Two Feet	$25,000	You
Sight of Two Eyes	$25,000	You
One Hand and One Foot	$25, 000	You
One Hand and Sight of One Eye	$25, 000	You
One Foot and Sight of One Eye	$25, 000	You
One Hand or One Foot	$12,500	You
Entire Sight of One Eye	$12,500	You

Loss of a hand or foot means that it is completely severed at or above the wrist or ankle joint. Loss of sight means that the sight in the eye is completely lost and cannot be restored or recovered.

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable. Your benefit will never exceed $25,000.

Additional Life Insurance/Accidental Death and Dismemberment Benefit

The Plan will provide an additional life insurance/accidental death and dismemberment benefit ("AD&D") for participants, and a life insurance benefit for their dependents. Participants are eligible for this benefit on the first day of the month following a period of any twelve consecutive month period during which the participant has worked 800 hours. A participant must work 800 hours during each twelve consecutive month period thereafter in order to maintain this coverage. However, employees who are disabled and receiving short-term disability benefits from the Welfare Fund, from Workers' Compensation, or from unemployment, will have their coverage continued up to three additional months from the date it would have terminated.

The benefit provided is as follows:

- Death/AD&D of participant: $50,000
- Death of participant's spouse: $25,000. This benefit terminates for the spouse when he or she reaches age 70.
- Death of participant's dependent child: $10,000. This benefit starts at 15 days from birth and ends when the dependent child reaches age 29.

Termination of the AD & D Benefit

Your accidental death and dismemberment benefit insured by Union Labor Life will terminate upon the earliest of:

1. the date the Fund's policy terminates;
2. the date you are no longer in a class of eligible persons under the policy;
3. the date premium payments on behalf of you cease;
4. the date you fail to pay the required premium, if any, when due; or
5. the month following the period of 12 consecutive months during which you did not work the required 600 hours.

Exclusions

No benefit is payable under this provision for any loss caused directly or indirectly, or in whole or in part by any of the following:

- bodily or mental illness of any kind;
- ptomaines or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- medical or surgical treatment of an illness or disease;
- suicide or attempted suicide;
- intentional self-inflicted injury;
- participation in a felony or a riot;
- war, or act of war, declared or undeclared; or any act related to war, or insurrection;
- services in the armed forces or units auxiliary to the armed forces; or

- travel or flight as a pilot or crew member in any kind of aircraft, including, but not limited to, a glider, a seaplane, or a hang kite. Coverage will be provided for persons who are fare-paying passengers on scheduled or chartered flights operated by a scheduled airline.

How to File a Claim or Appeal

For more information on how to file an AD&D benefit claim, and how to appeal a denied (whether in whole or part) claim, see the "Claims and Appeals Procedures" section.

NOTE: *This is not a complete benefit comparison or a contract, and should only be viewed as a summary to assist you in understanding your life insurance and AD&D benefits. You will also receive an individual certificate of insurance that summarizes your benefits. However, the terms, conditions, limits and exclusions are outlined in the policy and if there is any difference between the provisions of the certificate and/or this description and the policy, the provisions of the policy will govern.*

SHORT-TERM DISABILITY BENEFIT (NEW YORK STATE DISABILITY BENEFITS)

Short term disability benefits are temporary cash benefits paid to an eligible participant, when the participant is disabled by an off-the-job injury or illness. The Plan provides weekly cash benefits to replace, in part, wages lost due to injuries or illnesses that do not arise out of or in the course of employment (in accordance with New York State Disability Benefits Law). The benefit is administered by The Union Labor Life Insurance Company (Union Labor Life).

Eligibility

As a full-time employee working in covered employment, you are immediately eligible for short-term disability benefits once you have worked for four (4) consecutive weeks in covered employment. Eligibility for short-term disability benefits terminate when you stop working in covered Employment. However, after meeting the eligibility requirements, you remain eligible for benefits for a disability which begins within four weeks after your employment terminates and prior to the 6th day during the four weeks in which you work or you perform work with an employer who is covered under New York State Disability Benefits Law.

Once eligible for short-term disability benefits, if you have an illness or injury that is not work-related and that illness or injury makes you unable to perform all of the duties of your job or any other job which your employer offers you at your regular wages, you may be eligible to receive short-term disability benefits. Additionally, you may also be eligible for benefits if you suffer an illness or injury during periods of unemployment, which makes you unable to perform the duties of any job for which you are reasonably qualified. Also, you may be eligible for benefits as a result of a disability caused by or related to pregnancy.

The Plan will pay you weekly benefits when the Fund Administrator determines that:

- You became disabled while you are covered for short-term disability benefits;
- You are and you remain, because of the disability, under the care of a duly licensed physician, state licensed chiropractor, state licensed podiatrist, dentist, certified nurse midwife or state licensed psychologist; and
- You are not engaged in any other occupation or employment for which you are qualified by reason of education, experience or training.

Weekly Benefits

The amount of your benefits is generally equal to 50% of your average weekly wage (excluding overtime and bonuses) during the last eight weeks prior to disability (or shorter period if you have not worked in all eight weeks), with a maximum weekly benefit of $170. If you worked at any time during the last eight weeks, and the formula would give you a weekly benefit of less than $20, then your benefit would be $20.

Maximum Number of Weeks for Which Benefits Are Payable

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks.

Start of Payment of Disability Benefits

For employed workers, there is a seven-day waiting period during which no benefits are paid. Your right to a benefit begins on the eighth consecutive day of disability. If your disability is the result of non-occupational injury, benefits begin on the first day of disability.

When Payment of Disability Benefits Ends

Benefits will continue to be paid until the earlier of:

1. the date on which you are no longer disabled; or

2. after 26 weeks of benefits have been paid.

If you return to work and become disabled again as a result of the same injury or illness within three months of your return, the second occurrence will be considered part of the original disability and benefits will resume immediately. If the recurrence occurs more than three months after you return, a new waiting period applies.

In certain cases, your benefit may be reduced, or you may be required to refund a portion of your benefits to the Plan, because you received amounts payable under a workers' compensation law or other law or arrangement designed to compensate you for lost wages for the same period of time for which the disability benefits are being paid. Please contact the Fund Administrator for more information.

Exclusions

No benefits will be paid:

- For more than 26 weeks during a period of 52 consecutive weeks or during any one period of disability;
- You are no longer under the care of a duly licensed physician, state licensed chiropractor, state licensed podiatrist, dentist, certified nurse midwife or state licensed psychologist;
- For any day of disability for which the participant performed work for compensation;
- For any disability occasioned by the willful intention of the participant to bring about injury to the participant or another;
- For any disability arising out of any illness or injury due to any act of war, either declared or undeclared;
- For any disability commencing before the employee becomes eligible for benefits; or
- For benefits payable under workers' compensation or other applicable law.

Applying For Benefits

If you are currently employed in covered employment or unemployed less than four weeks, file the claim with the Fund Administrator, using New York State Form DB-450, or such other form available from the Fund Administrator. Once you have become unemployed for at least four weeks, you must file for short-term disability benefits through your unemployment office. You must file your claim within 30 days after you become disabled. If you file late, you will not be paid for any disability period more than two weeks before the claim is filed. Late filings may be excused if it is shown that it was not reasonably possible to file earlier. No benefits will be paid if you file more than 26 weeks after your disability begins.

In addition to the claim form, your health care provider must complete and sign the portion of the disability form entitled "Health Care Provider's Statement" as proof of your disability.

Before filing your claim, be sure that you have completed and signed the form and your health care provider or practitioner has completed and signed his or her portion. Submit this information promptly to avoid delaying your claim.

If a claim is properly completed with the required statements, the first payment will be made within four business days after the 14th day of disability or four business days after the receipt of the claim, whichever is later. Benefits are payable each week during your period of disability.

Proof of Disability

The application for benefits must include proof for your claim. Union Labor Life may require additional proof of continuing disability but may not require such proof more than once a week. Union Labor Life reserves the right to review the medical records of any health care provider who provides medical care and treatment

to you during any period in which benefits are being requested or paid. Union Labor Life also reserves the right to have you examined, at the Plan's expense, by a health care practitioner of its choice as often as may be reasonable during the period which benefits are being requested or paid.

Denial of Disability Claims

If denied, you will be sent a "Notice of Total or Partial Rejection of Claim for Disability Benefits" – Form DB-451. This rejection notice will include the reason for the denial of benefits.

Appeals Rights

If you disagree with the rejection of your claim, on the back of the rejection form is a section entitled "Claimant's Request for Review." Complete this section and mail it to the address below within 26 weeks of the rejection of your claim (whether in whole or part) if you wish to request a review of the rejection of your claim. Complete this section by providing a statement of the specific reason for requesting a review. Attach any additional medical evidence, employment records or other evidence you feel support your request. Where necessary, the Workers' Compensation Board will obtain further information and may hold a hearing on the claim. Benefits will be paid if a claim is determined proper and valid.

Appeals must be in writing and sent to:

Workers' Compensation Board
Disability Bureau
100 Broadway – Menands
Albany, New York 12241

You will be notified in writing of the decision of the Workers' Compensation Board.

For More Information

Contact the Fund Administrator at (212) 505-5050 or Union Labor Life at 1-800-431-5425.

VACATION AND SUPPLEMENTAL BENEFITS

The benefit provides vacation, supplemental unemployment, disability, medical hardship and death and/or retirement benefits. These benefits are paid in the following manner.

Vacation Benefit

Employers contribute an amount for each hour worked by Plan participants as set forth in the applicable collective bargaining agreement. The amount accumulated in each participant's vacation account as of March 31st and September 30th of each year is paid on or before April 30th and October 31st of each year to the participant unless the participant elects to hold the amount in the vacation account. In addition, a participant may, upon request to the Local 197, make an application for a vacation benefit no more frequently than once per month. The request for such vacation benefit must be made no later than the third Monday of the month in order to receive a vacation benefit check that month.

Supplemental Unemployment, Disability, and, Death Benefit

A participant who becomes unemployed, ill, injured or disabled, is entitled to supplementary benefits under the Plan provided he is receiving benefits under the New York State Unemployment Insurance Department, Derrickmen's Welfare Fund's short-term disability insurance carrier, or the workers' compensation board. A benefit rate of $200 per week will be paid from the participant's supplemental benefits account for the number of weeks the participant is entitled to receive benefits under the applicable state law, or until the participant has either collected $2,600 or exhausted the account balance from the Fund in supplemental benefits, whichever occurs first. Proof of disability or unemployment must accompany the application and be provided on a regular basis during the period of disability and unemployment.

Upon the death of a participant, the supplemental benefit account balance will be paid to his or her designated beneficiary as a death benefit.

Benefits Provided

You will be entitled to receive a vacation fund benefit check from the Welfare Fund twice a year. Employer contributions, which are based on your hours worked, are automatically banked by the Welfare Fund. These contributions commence from the first day of work. You will see your banked contributions on your pay stub every time you get paid. If you would like to know the amount of your entire balance of banked contributions, simply call the Fund Administrator.

How to File a Claim or Appeal

You do not need to file a claim in order to receive your vacation fund benefit. Your benefit is automatically paid by the Welfare Fund twice a year. If you would like to know when you will receive your vacation fund benefit check, simply call the Fund Administrator. For more information regarding a vacation and supplemental benefit claim, and how to appeal a denied (whether in whole or part) claim, see the "Claims and Appeals Procedures" section.

CLAIM PROCEDURES

This section describes the procedures for filing claims for benefits from the Derrickmen's Welfare Fund, Local 197 (the Plan), for Prescription Drug, Optical, Dental, and Vacation and Supplemental benefits, and insured Short-Term Disability, Life and Accidental Death and Dismemberment (AD&D) claims.

Procedures for filing claims and appeals procedures for insured Medical (medical/hospital) benefits are described in the insurance company's Certificate of Coverage located in the Appendix of this document. A full description of your claims and appeals rights are described in the Life, AD&D and Short-Term Disability Certificate of Insurance issued by the insurance company. The certificates also describe the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational). The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For prescription drug benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process has been exhausted.

General Information

See the *Contact Chart* found at the beginning of this document for a list of Claims Administrators for Prescription Drug, Optical, Dental, Retiree benefits (Death Benefit), and Vacation and Supplemental benefits, and insured Short-Term Disability, Life and Accidental Death and Dismemberment (AD&D) claims. See the Certificate of Coverage found in Appendix A for information on claims and appeals procedures for insured Medical (medical/hospital) benefits.

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form.

Authorized Representatives. An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Administrator to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Types of Claims

Health Benefit Claims. Health benefit claims can be filed for Prescription Drug, Optical, Dental benefits. There are four categories of health claims as described below. In general, the Plan does not require approval for any Prescription Drug, Optical, Dental, or Retiree benefits before health care is obtained. Therefore, the only types of claims covered by these benefits are Post-Service Claims.

- **Pre-Service Claims**. A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is NOT required for any benefits.

- ***Urgent Care Claims***. An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims***. A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims***. A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Short Term Disability Claim. A Short Term Disability Claim is a request for benefits during a period of disability. Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

Life Insurance and Accidental Death and Dismemberment Insurance Claims. A Life Insurance and Accidental Death and Dismemberment Insurance Claim is a request by a designated beneficiary for benefit payment following the death of the participant. A claim for Accidental Death and Dismemberment Benefits may also be filed by a participant after he or she has provided the Plan with proof of a bodily loss.

Vacation and Supplemental Benefits. A Vacation or Supplemental claim is a request for benefits for vacation or supplemental benefits.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);

- Be received by the Plan Administrator or Claims Administrator (as applicable);

- Name a specific individual participant and his/her Social Security Number;

- Name a specific claimant and his/her date of birth;

- Name a specific medical condition or symptom;

- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);

- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and

- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the applicable Claims Administrator, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

When Claims Must Be Filed

Claims for Short-term Disability, Life and AD&D benefits should be filed within 90 days following the date of loss. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 12-months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Decision Timeframes

Health Care Claims

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a

new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Pre-Service Claims. Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt. Notification will be provided in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part). The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period. If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process. If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Urgent Care Claims. In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form. The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification. If you improperly file an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

Concurrent Claims. If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated. A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section. If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as

applicable) notice provided no later than three (3) calendar days after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

Post-Service Claims. Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Short-Term Disability Claim Procedures

Claims will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

Life Insurance and Accidental Death and Dismemberment Insurance or Death Benefit

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator), you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Vacation And Supplemental Benefits

The Claims Administrator will make a decision on a vacation and supplemental benefit claim within 90 days of receipt of a written claim for benefits. Under special circumstances, an extension of time for up to 90 days may be required. If the extension is needed, written notification will be provided prior to the end of the initial 90-day period of the special circumstances requiring the extension of time and the date when a decision will be made.

If an extension is required because of your failure to provide necessary information, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the additional information.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, 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;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

- A rescission of coverage, whether or not there is an adverse effect on any particular health disability/STD benefit. An adverse benefit determination does not include rescissions of coverage with respect to life insurance/dependent life insurance/accidental death and dismemberment insurance/death benefits.

Notice of Adverse Benefit Determination

Initial Determinations of Benefit Claims

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims – include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);

- Give the specific reason(s) for the denial (and for health benefit claims - include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review for health benefit claims);

- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.

- Reference the specific Plan provision(s) on which the denial is based;

- Describe any additional material or information needed to perfect the claim and an explanation of why such additional information is necessary;

- With respect to health and short term disability claims, the opportunity, upon request and without charge, to reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;

- Provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;

- Contain a statement that you have the right to bring a civil action under ERISA section 502(a) following an appeal;

- With respect to health and short term disability claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

- If the denial of a health care claim and short term disability claims was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

- With respect to a short term disability claim, a discussion of the Insurer's initial claim decision, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Insurer does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Insurer, regardless of whether or not the advice was relied upon by the Insurer in making an adverse benefit determination;

- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Appeals Procedures

Prescription Drug, Optical, Dental, Retiree benefits (Death Benefit), and Vacation and Supplemental benefits, and Insured Short-Term Disability, Life and Accidental Death and Dismemberment (AD&D) Benefits

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund, within *180 days* after you receive notice of denial, except for life insurance, AD&D, and vacation and supplemental benefit claims which have a 60-day time limit for filing an appeal.

Post Service Prescription Drug, Optical, Dental, Retiree benefits (Death Benefit), and Vacation and Supplemental Benefit. Appeals should be made in writing to the Board of Trustees at:

Derrickmen's Welfare Fund, Local 197
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, New York 10001
(212) 505-5050

Your request for review must be made in writing within 180 days after you receive notice of denial except for vacation and supplemental benefits which have a 60-day time limit for filing an appeal.

To appeal a pre-service claim for prescription drugs, you should contact the Plan's pharmacy benefits manager (PBM) whose contact information can be found in the Contact Chart at the beginning of this document.

Insured Life Insurance Claims and AD&D. Appeals should be made in writing to The Union Labor Life Insurance Company at:

The Union Labor Life Insurance Company (Union Labor Life)
8403 Colesville Road
Silver Spring, MD 20910

Your request for review must be made in writing within *60 days* after you receive notice of denial.

Short-Term Disability. Appeals should be made within one year to:

Disability Benefits Bureau
Worker's Compensation Board
100 Broadway-Menands
Albany, NY 12241

Review Process

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments. As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, to reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- With respect to health and short-term disability benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- With respect to health and short-term disability benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit

determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- With respect to health and short-term disability benefit claims appeals, continued coverage during the pendency of the appeal process; and

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

  - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Timing of Notice of Decision on Appeal

- **Post Service Prescription Drug, Optical and Dental.** Decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

- **Pre-Service Claims**. A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received. No extension is permitted.

- **Urgent Care Claims**. This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

- **Concurrent Claims**. You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Life and AD&D Claims:** Union Labor Life will decide your appeal and notify you in writing within 60 days of its receipt of your request for review. Under special circumstances, an extension of time, not exceeding 60 days, may be required. If such an extension is needed, Union Labor Life will notify you or your beneficiary, in writing before the 60-day period expires, of the special circumstances and the date by which a decision will be made. You will receive a written notice of the decision from Union Labor Life.

- **Short-Term Disability Claims:** You will receive a decision from the applicable agency.

- **Retiree, Death, Vacation and Supplemental Benefit Claims:** The Board of Trustees will make its decision on review of the denial promptly and not more than 60 days after receipt of the request for review. If special circumstances require an extension of time for processing the review, notice of such extension shall be furnished prior to the expiration of the 60-day period. The notice of extension shall indicate the special circumstances requiring an extension of time and the date by which the Trustees expect to render the determination on review. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide the appeal, the period for making the benefit determination on review shall be tolled from the date on which the notification is sent to the claimant until the date on which the claimant responds to the request for additional information. A decision shall then be rendered as soon as possible, but not later than 120 days after the receipt of the request for review.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

- Reference to the specific Plan provision(s) on which the denial is based;

- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

- A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;

- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

- If the denial of a health or short-term disability benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;

- If the denial of a health or short-term disability claim, was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;

- With respect to short-term disability claims, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with(i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was

obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. With respect to disability/STD benefit, the law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

Elimination Of Conflict of Interest

With respect to disability/STD benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

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

EXTERNAL REVIEW OF PRESCRIPTION DRUG CLAIMS

If your initial claim for Prescription Drug benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO").

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims for Prescription Drugs, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.

- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.

- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.

- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits other than health care benefits such as [disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits].

- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process. Please refer to the Certificate of Coverage which can be found in Appendix A for details.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination. Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan

Within five (5) business days of receipt of your request for external review of a standard claim, a preliminary review of the request will be completed to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.

- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)

- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review Of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims. Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.

- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review Of An Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

Follow the same procedures as for an External Review of a Standard Review of a Standard Claim to begin a request for expedited external review.

Preliminary Review Of An Urgent Care Claim By The Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the

claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

SUBROGATION/REIMBURSEMENT

If you or an eligible dependent is injured in an accident caused by a third party and the Plan pays a claim for benefits for you or your eligible dependent, the Plan has the right to be reimbursed by the third party or to be repaid from any settlement or judgment made in your or your dependent's favor against the third party. In consideration of any benefit payments made by the Plan, you or your dependents will subrogate (assign) to the Plan your right of recovery against any person or entity and any action in tort to the extent of the amount of you or your dependent's claim. In other words, if someone negligently injures you and the Plan provides you with benefits to care for that injury, you must reimburse the Plan out of whatever you may recover from the wrongdoer.

Individuals Covered by Provision

The Plan shall be entitled to subrogation and/or reimbursement of all rights of recovery of a participant, his or her parent(s) and dependent(s) or a representative, guardian or trustee of the participant, parent(s) or dependent(s) (hereinafter, collectively "claimant").

Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement or otherwise, that may be liable for a claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Insufficient Recovery Amount

If the recovery amount is not sufficient to reimburse the Plan in full, the remainder must be paid by the claimant. The Plan will receive a credit up to the full amount of any remainder the Plan paid to the claimant to apply against any future benefit obligation arising out of the injury, sickness or death that was the subject of the claim resulting in the settlement or judgment.

Rights to Reimbursement With Source of Funds Specifically Identified

The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment or payment from any source liable for making a payment relating to the claimant's injury, illness or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law and an individual policy of insurance maintained by a claimant.

Rejection of Make-Whole Doctrine

Such subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. The Plan's rights will not be defeated or reduced by the application of the "Make-Whole Doctrine" or any other doctrine purporting to defeat the Plan's right by allocating the proceeds exclusively or in part, to non-medical expense damages.

Equitable Lien by Agreement

Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the eligible employee or dependent from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds

The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery. The claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives designated by the Plan. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

First-Dollar Recovery

The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement or otherwise, regardless of whether a claimant is made whole. If claimant makes a recovery in a claim from any party and the proceeds are not allocated as required, the Trustees have the right to make a claim for reimbursement, including but not limited to, claims for restitution, unjust enrichment or a constructive trust over any recovery by claimant, to the extent of the Plan’s expenditures, whether the recovery is paid to, or in the possession of claimant, claimant’s attorney, or any other individual or entity, or to take a credit on future Plan obligations to claimant. Such credit will not be limited to future obligations of the Plan to the actual receipt of such benefits, but also may be taken against any future obligations to claimant.

Disavowal of Common Fund Doctrine

The Plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Plan Administrator, in his or her sole discretion, agrees in writing to discount the Plan's claim by an agreed-upon amount of such fees or expenses.

The Plan specifically disavows any claims that an eligible employee or dependent may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common fund doctrine.

Cooperation

The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement. The completion and/or execution of any documents requested by the Plan Administrator shall be a condition to receiving payment for a claim. Further, the Plan shall have the right to suspend all benefit payments due to a claimant, the employee of whom a claimant is a dependent and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.

Assignment

The claimant cannot assign any rights or causes of action that it may have against a third party to recover expenses for claimant's injury or illness without the express written consent of the Plan.

Future Benefits

The Plan may reduce future payment of benefits to participants and beneficiaries as an offset against amounts owed to the Plan by claimant.

Other Subrogation/Reimbursement Rights

The insurance company for hospital, major medical and prescription drug benefits have rules regarding third party payments subrogation which are outlined in the certificate.

YOUR ERISA RIGHTS

STATEMENT OF ERISA RIGHTS

As a participant in the Derrickmen Welfare Fund, Local 197 you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office - 253 West 35th Street, 12th Fl, New York, NY 10001 all documents governing the Plan, including insurance contracts and 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 (formerly known as the Pension and Welfare Benefit Administration).

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. 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, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

1. 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.

2. 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

1. 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, as discussed in the Claims Filing and Appeals Information section of this document.

2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

3. 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. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit.

4. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

5. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

MISCELLANEOUS PROVISIONS

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- Amendments to the Plan may be made in writing by and become effective on the written approval of the Board of Trustees or on such other date as may be specified in the document amending the Plan.

- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverages may be added by the Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of assets upon termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.

- To alter or postpone the method of payment of any benefit.

- To amend or rescind any provision of these Plan Rules.

In addition, the Plan may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program 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. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder.

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. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

STATEMENT OF FUND'S RIGHTS

A. The Fund, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of participants, as defined by law.

B. The terms of this Derrickmen's Welfare Fund, Local 197 summary plan description supersede the terms of any contrary information about the Plan, or the Plan's eligibility, benefits, limits or exclusions, that is provided orally or in writing to a participant by a contributing employer or anyone other than the Plan Administrator.

NO LIABILITY FOR THE PRACTICE OF MEDICINE OR DENTISTRY

The Plan, Plan Administrator, Trustees or any of their designees are **not** engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, 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.

OVERPAYMENTS

If a person has been paid benefits by the Plan that either should not have been paid or are in excess of the benefits that should have been paid, the Plan may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such person or other present or future amounts payable to such person. The Plan, in its sole discretion, may also recover such amount by any other legal means.

GENERAL PLAN INFORMATION

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Name of The Plan

Derrickmen's Welfare Fund, Local 197

Name and Address of Plan Sponsor Maintaining the Plan

Board of Trustees
Derrickmen's Welfare Fund, Local 197
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

Employer Identification Number (EIN) and Plan Number

13-1621369/ 501

Type of Plan

Employee welfare benefits plan providing major medical, hospital, dental, optical, prescription drug, short-term disability, term life insurance and accidental death and dismemberment benefits.

Type of Administration

The Plan is maintained pursuant to one or more collective bargaining agreements. All contributions to the Plan are made by employers in accordance with their collective bargaining agreements with Derrickmen's Local 197. The Fund Administrator will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreement. The Fund Administrator will also provide you, upon written request, a list of contributing employers and employee organizations.

The collective bargaining agreements require contributions to the Plan at fixed rates per hours worked. You may request in writing, a copy of the collective bargaining agreement from the Fund Administrator and a copy is also available for examination by participants and dependents at the Fund Office.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Most of the benefits are provided through insurance policies. The Fund's assets and reserves are invested in savings accounts and federal securities in numerous banks.

The Welfare Fund is self-funded with respect to dental, optical, prescription drug and Retiree and vacation and supplemental benefits under the Plan. These benefits are administered by the Fund Office whose contact information can be found in the *Contact Chart*. Medical and hospital benefits are provided under a group insurance contract entered into between the Derrickmen's Welfare Fund, Local 197 and the insurance company. Life insurance, accidental death & dismemberment ("AD&D") and short-term disability benefits are provided under a group insurance contract. The name and address of the Insurance Companies can be found in the *Contact Chart* at the beginning of this document

Plan Administrator/Plan Sponsor

Board of Trustees of the Derrickmen's Welfare Fund, Local 197
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

Agent For Service Of Legal Process

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

For disputes arising under those portions of the Plan insured under a group insurance contract service of legal process may be made upon the insurance company at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Plan Trustees

Union Trustees	**Employer Trustees**
Mr. William Hayes Derrickmen's Union Local 197 25-19 43rd Avenue Long Island City, NY 11101	
Mr. Christopher Gorman Derrickmen's Union Local 197 25-19 43rd Avenue Long Island City, NY 11101	Mr. Marco Berardi Berardi Stone Setting 525 North Broadway White Plains, New York 10603
Ms. Carole Raftrey Derrickmen's Union Local 197 25-19 43rd Avenue Long Island City, NY 11101	Mr. Robert Weiss, Vice President A.J. McNulty & Co., Inc. 53-20 44th Street Maspeth, NY 11378
Mr. Thomas Wilson Derrickmen's Union Local 197 25-19 43rd Avenue Long Island City, NY 11101	Mr. Anthony Vespa, President Vespa Stone LLC 102 Fairview Park Drive Elmsford, NY 10523

Plan Year

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

Plan Contracts Govern

Nothing in this SPD is meant to interpret or change in any way the provisions expressed in written agreements, the insurance policies or the master contracts. If there is a difference between this SPD and those other documents, the written agreements, certificates, insurance policies, or master contracts will govern.

PRIVACY

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 group health plans like the this one 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 an employer who participates in this Fund 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) and Paid Family Leave (PFL).

A complete description of your rights under HIPAA can be found in the Plan's Notices of Privacy Practices which were previously distributed to you. A Notice of Privacy Practice for insured Medical benefits is available from the insurers whose contact information can be found in the *Contact Chart* at the beginning of this document. A Notice of Privacy Practices for the self-insured benefits is available from for the Fund 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 will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") 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. When referred to in this section, the Plan means the insurer for insured Medical benefits and the Fund for self-insured benefits.

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.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    - **Treatment** is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

    - **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:

        a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

b. 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; and

c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

a. 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;

b. 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;

c. 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;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. 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.

f. 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.

B. Generally, the Plan will require that you sign a valid authorization form 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.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. 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;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

10. 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; and

11. Notify you if a breach of your unsecured protected health information (PHI) occurs.

D. In order to ensure that adequate separation between the Plan (for self-insured benefits) and the Plan Sponsor is maintained in accordance with HIPAA, only designated Fund Office staff and business associates under contract to the Welfare Fund may be given access to use and disclose PHI.

E. 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 Fund. 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 Fund's Privacy Officer.

F. In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Will ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. 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 dental plan options, self-funded vision plan options and COBRA administration.

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

Derrickmen's Welfare Fund, Local 197 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Derrickmen's Welfare Fund, Local 197:

a. Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b. Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator.

If you believe that Derrickmen's Welfare Fund, Local 197 has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kenneth S. Cook, Administrator
253 West 35th Street, 12th Floor
New York, NY 10001
Telephone: (212) 505-5050

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kenneth S. Cook is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (212) 505-5050.
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (212) 505-5050
3. French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (212) 505-5050
4. Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (212) 505-5050.
5. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (212) 505-5050.
6. Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (212) 505-5050.
7. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (212) 505-5050.
8. Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با(212) 505-5050 تماس بگیرید.
9. Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (212) 505-5050 पर कॉल करें।
10. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (212) 505-5050.
11. Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih (212) 505-5050
12. Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 505-5050 (212) (رقم هاتف الصم والبكم: 505-5050 (212)
13. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (212) 505-5050번으로 전화해 주십시오.
14. Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (212) 505-5050.
15. Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (212) 505-5050.

APPENDIX

BLUE CROSS BLUE SHIELD CERTIFICATE

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