Allied Building Inspectors
Local No. 211

International Union of Operating Engineers

225 Broadway, 43rd Floor
New York, N.Y. 10007

WELFARE FUND BENEFITS

As Amended through January 1, 2023

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GUARDIAN OF THE PUBLIC SAFETY

Table of Contents

ALLIED BUILDING INSPECTORS
Local No. 211
I.U.O.E. Welfare Fund

225 Broadway, 43rd Street
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Local 211, I.U.O.E.
225 Broadway, 43rd Floor
New York, N.Y. 10007

Employers
City of New York
N.Y.C. Housing Authority
and Other Related Agencies

Employer Identification Number:
13-612292272

Plan Number
501

INTRODUCTION

The Allied Building Inspectors Local 211, I.U.O.E. Welfare Fund was established as a result of collective bargaining between Local 211 and The City of New York and various related agencies. Contributions to the Fund are as stipulated in the Collective Bargaining Agreement. There is no requirement that employees contribute to the Fund in order to be eligible for benefits provided by the Fund. The employer contributions to the Welfare Fund are used to provide benefits for covered employees, eligible retired employees, and eligible dependents; and to finance the cost of administration.

A copy of the Collective Bargaining Agreement ("CBA") and a complete list of contributing employers are available for examination at the Fund Office. Upon written request, the Participant may obtain a copy of the CBA or the list at a reasonable charge or a statement whether a particular employer is part of the Plan.

The Fund is governed by a Board of Trustees in accordance with the Agreement and Declaration of Trust, as amended from time to time, by which the Welfare Fund was created. The present members of the Board of Trustees are listed in this booklet and their address for Fund business is c/o Allied Building Inspectors Local 211, I.U.O.E. Welfare Fund, 225 Broadway, New York, NY 10007. Any service of legal process should be sent to the Board of Trustees at that address.

This booklet describes eligibility requirements, how claims should be presented for payment, and the procedure for making appeals to the Trustees. All of the benefits described in this booklet are self-insured and most are self-administered, except for the Prescription Drug and Dental Benefits. There are no insurance carriers underwriting or administering the benefits provided by the Fund.

In addition to the Agreement and Declaration of Trust and any other agreements, rules and regulation governing the operation of the Fund, the Fund is also subject to federal, state and local law, designed to protect eligible employees, retired employees, and eligible dependents. The Fund submits its books to audit by a certified public accountant and annual reports are available for inspection, by appointment, at the Fund Office. The Fund's fiscal records are maintained on a calendar year basis.

Please Note

This Summary Plan Description also serves as the Plan document (Plan). In the event of a conflict between the description of any Plan provision in this booklet, and the language of any underlying Plan documents that may exist, such as insurance contracts and the like, the language contained in the Plan documents is the official and governing language.

The Plan, Agreement and Declaration of Trust, and personnel at the Fund Office are the only authorized sources of Plan information. The Trustees of the Fund have not empowered anyone else to speak for them with regard to the Plan. No employer or supervisor is in a position to discuss your rights under this Plan with authority.

If you have a question about any aspect of your participation in the Plan, you should, for your own records, write to the Trustees. You will receive a written reply, which will provide you with a permanent reference. All correspondence to the Fund Office must contain your name and identification number. Correspondence received without such information will cause a delay in processing.

The address of the Fund Office/Plan Administrator is:

Allied Building Inspectors
Local 211, I.U.O.E. Welfare Fund
225 Broadway, 43rd Floor
New York, NY 10007

IMPORTANT NOTICE

The Board of Trustees of the Allied Building Inspectors Local 211 I.U.O.E. Welfare Fund is authorized, at any time and on such basis as it, in its sole discretion, deems appropriate, to amend, modify, add to or eliminate any provision or benefit from the Plan of benefits. Such changes in the benefits may be made by formal Plan amendment, Board of Trustees resolution, action by the Board of Trustees when not in session by telephone or written action, and/or such other methods as may be permissible for action by the Board of Trustees. The Board of Trustees also reserves the right to terminate the Plan, at any time for any reason, under the conditions set forth in the Plan Documents.

Notice Required by the Affordable Care Act

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provisions of preventative health services without any cost sharing. However, grandfathered health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections do and do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Allied Building Inspectors Local 211, I.U.O.E. Welfare Fund, 225 Broadway, 43rd Floor, New York, NY 10007.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

COVERED JOB TITLES

Job Titles Included For Coverage Under This Plan are:

Inspector of Low Pressure Boilers
Boiler Inspector
Construction Inspector
Elevator Inspector
Heating and Ventilating Inspector
Hoist and Rigging Inspector
Housing Inspector
Housing Construction Inspector (NYCHA)
Hull and Machinery Inspector
Inspector of Cement Tests
Inspector of Concrete Tests
Plastering Inspector
Plumbing Inspector
Steel Construction Inspector
Building Rehabilitation Specialist
Associate Inspector Low Pressure Boilers
Associate Boiler Inspector
Associate Construction Inspector
Associate Elevator Inspector
Associate Heating and Ventilation Inspector
Associate Hoist and Rigging Inspector
Associate Housing Inspector
Associate Housing Construction Inspector (NYCHA)
Associate Inspector of Cement Tests
Associate Plastering Inspector
Associate Building Rehabilitation Specialist
Multiple Dwelling Specialists
Principal Multiple Dwelling Specialists
Multiple Disciplinary Inspector

Apprentices are also covered by the above job titles.

DEFINITIONS

1. "Covered Job Title" means a job category that is covered by a collective bargaining agreement and welfare fund agreement between the Employer and the Union, under the terms of which agreements the Employer is required to make contributions to the Allied Building Inspectors Local 211 Welfare Fund on behalf of all persons employed in such job categories.

2. "Dentist:" (D.D.S.) means a person qualified by law to practice dentistry in the state in which treatment is rendered.

3. "Dependent" means the employee's legal spouse or domestic partner and all lawful dependents, (defined as the employee's biological child(ren), legally adopted child(ren), stepchild(ren), or the child(ren) named in a Qualified Medical Child Support Order) children up to the age of twenty-six (26) years, or at all ages in the case of a child who resides in the household of the employee and who was initially covered by the Plan prior to age 26 and who is totally disabled by a mental or physical impairment which makes the child incapable of engaging in any gainful employment provided medical evidence of such impairment is furnished to the fund within 31 days after the date such child attained age 26. However, children under the age of 26 whose employment provides them with employer-sponsored healthcare insurance coverage through the dependent's employment and accepts the coverage, will not be covered.

4. "Employee" means a person who is employed by the Employer in a Job Title for which the Union is the certified collective bargaining representative, and on whose behalf the Employer is required to make contributions to the fund in accordance with a collective bargaining agreement and supplementary welfare fund agreement.

5. "Employer" means the City of New York, or any other agency with which the Union may reach agreement.

6. "Fund" means the Allied Building Inspectors Local 211, I.U.O.E. Welfare Fund.

7. "Medical Doctor, Physician or Surgeon" means a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (O.D.).

8. "Pediatric" means age newborn to age 19.

9. "Plan Year" means the calendar year (January 1st to December 31st).

10. "Retired Employee" means a person who is in receipt of a pension benefit from the New York City Employees Retirement System effective on or after July 1, 1970 and for whom employer contributions are made on his behalf. Retired Employees will be entitled to all benefits except Disability and Accidental Death and Dismemberment Benefits.

11. "Union" means the Allied Building Inspectors, Local 211, I.U.O.E. AFL-CIO.

ELIGIBILITY

A. For Employees:

An employee shall become eligible for benefits of the Plan as of the day next following completion of one day of work for the employer in a Covered Job Title. If an employee is absent from work on the day his eligibility would have commenced, his eligibility shall commence as of the date he returns to work in a Covered Job Title.

In order to qualify for benefits, an employee must have on file with the office of the Plan a signed enrollment form providing data as to his employment status, social security number, birth date, family status, birth dates and sex of his dependents, and name and address of beneficiary.

B. For Retired Employees:

A retired employee shall become eligible for benefits of the Plan if he retires effective on or after July 1, 1970 under the City of New York Employees Retirement System and employer contributions are made on his behalf to this Fund.

C. For Dependents:

A dependent shall become eligible for benefits of the Plan as of the latter of the following:

1. The date on which the employee becomes eligible; or

2. The date on which the employee acquires the dependent. Proof of the above must be submitted to the Fund Office.

D. Termination of Eligibility:

An employee's eligibility shall terminate as of the date on which he ceases to be employed in a Covered Job Title and the employer is no longer required to make contributions to the Fund on his behalf.

A dependent's eligibility shall terminate on the earliest of the following dates;

1. The date on which the employee's eligibility terminates;

2. In the case of a spouse, on the date this dependent ceases to be the legal spouse of the employee, or the date on which the spouse becomes eligible for benefits as any employee under this Plan;

3. In the case of a child, on the date the child ceases to be a "Dependent" as defined in paragraph 7 of the section headed "Definitions", or on the date the child becomes eligible as an employee under the Plan.

E. Extension of Benefits:

In the event an employee changes to a no-pay status because of disabling illness or injury which commenced while he was eligible for benefits, the disability benefit will continue to the conclusion of the disability period. In the event of termination or resignation, the disability benefits will also cease.

F. Leaves of Absence for Military Service:

If you are on active military duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active military duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your Dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA. See the "COBRA Coverage" section in this booklet for a full explanation of the COBRA coverage provisions, which will allow you to continue your coverage. In addition, your Dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS). This Plan will coordinate coverage with CHAMPUS.

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

1. ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

2. fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or

3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

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

Call the Fund Office if you have questions regarding coverage during such leave.

G. Continuation of Coverage After Termination of Eligibility (COBRA)

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying

event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events;

The end of employment;
Reduction of hours of employment; or
Death of the employee.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Fund Office.

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage must be elected no later than 60 days from the later of the date of the loss of coverage caused by the qualifying event of the date the qualifying beneficiary is notified of his or her right to COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under this Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

Cancellation of Continuation Coverage

The federal law provides that COBRA may be cancelled by the Plan for any of the following reasons:

1. You do not make the required self-payments or premium payments on time.

2. The plan itself terminates.

3. Your employer no longer provides health care coverage to any of his employees.

4. You become an employee covered under some other group health care plan and immediately satisfy any waiting periods imposed under a new employer's plan.

5. You are divorced from the covered employee, remarry and become covered under your new spouse's group health care

plan. If the new spouse's plan has a waiting period, COBRA coverage must be continued until the waiting period is satisfied but no longer than a maximum of 12 months.

6. You, as an employee, a spouse, or dependent, become covered under Medicare subject to the following exception:

   Although an employee's COBRA coverage may be cancelled as soon as he or she is covered by Medicare, a spouse or dependent child with COBRA coverage at that time may continue purchasing such coverage for up to 18 or 36 months minus any months of COBRA coverage received immediately prior to the employee's coverage under Medicare. This option applies only if a spouse or dependent child is not covered by Medicare.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 your Plan informed of address changes

To protect your family's rights, let the Allied Building Inspectors Local 211 Welfare Fund know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Allied Building Inspectors Local 211 Welfare Fund
225 Broadway, 43rd Floor
New York, NY 10007
(212) 233-2690

GENERAL PROVISIONS

An Employee, retired employee or an eligible dependent or beneficiary of an employee, shall file an application for benefits at the offices of the Fund on designated claim forms issued by the Plan. Claims for benefits should be filed within 180 days after the occurrence for which benefits are claimed except for disability. Claims filed later than 180 days after the occurrence may be declared invalid, unless the claimant submits an explanation which is satisfactory to the Trustees as to why the filing of the claim was delayed.

In order to verify the accuracy of any claim, the Fund shall require the employee, retired employee or eligible dependent or beneficiary to submit with any claim the appropriate documentary evidence, including copies of hospital bills, surgical bills, dental x-rays, and death certificates. The Fund may also require, as a condition for eligibility for benefits, that the employee, retired employee, eligible dependent or beneficiary authorize the Fund to secure medical or dental care records from hospitals, physicians or dentist and any other service which the Fund deems necessary for determining claims questions.

If at any time there is an overpayment by the Welfare Fund due to misrepresentation, misinterpretation of claim or clerical error, the employee will be notified, and such overpayment shall be refunded to the Welfare Fund.

Except for payments made to the Prescription Drug Benefits Administrator, Dental Benefits or the participating Optical Company, the Fund does not recognize and will not honor any other assignment of benefits, which shall be payable solely to the employee; or in the case of Death Benefits, to the beneficiary duly designated by the employee; or retired employee; or to such other person or persons provided for by the Plan, as follows:

In the event of the death of an employee who has failed to designate a beneficiary in the manner prescribed by the Fund, or in the event the designated beneficiary is deceased, the Fund shall pay the Death Benefit and/or Accidental Death Benefit as follows:

- **First:** to the spouse, or if the spouse is not living,
- **Second:** to the administrator or executor of the deceased employee's estate.

If the beneficiary is a minor or is, in the judgment of the Trustees, incapable of giving valid receipt for any payment due him, the Fund shall pay the benefits to

the legally appointed guardian of such beneficiary, upon submission to the Fund of proof of such appointment.

Welfare Fund payments cannot be paid after the death of the active or retired member until the estate requests it, with the exception of death benefits.

FAMILY AND MEDICAL LEAVE ACT

If you (as a Participant) qualify for a family or medical leave of absence in accordance with the Family Medical Leave Act of 1993 (FMLA), then your eligibility will be continued under the Plan provided your employer makes the required contributions on your behalf. Eligibility may be continued for up to twelve (12) weeks during a twelve (12) month period, for any of the following reasons:

1. to care for your child after the birth or placement of a child for adoption or foster care; so long as such leave is completed within twelve (12) months after the birth or placement of the child;

2. to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

3. for your own serious health condition.

In the event you and your spouse are both covered as Participants, the continued coverage under (a) may not exceed a combined total of twelve (12) weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of twelve (12) weeks.

Eligibility

(a) You are eligible to continue your coverage under FMLA if:

1. you have worked for your employer for at least one (1) year;

2. you have worked at least 1,250 hours over the previous 12 months for such employer;

3. your employer employs at least 50 employees within 75 miles of your work site; and

4. your employer continues to pay your required contributions.

(b) If, on the day your eligibility is to begin, you are already on an FMLA leave, you will be considered actively at work. Benefits for you and any Eligible Dependents (if applicable) will be in accordance with the terms of the Plan as herein set forth.

You and your Eligible Dependents (if applicable) are subject to conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

(c) FMLA continuation ends on the earliest of:

1. The day you return to work;

2. The day you notify your employer that you are not returning to work;

3. The day your coverage would otherwise end under the Plan; or

4. The day coverage has been continued for 12 weeks.

COORDINATION OF BENEFITS

If an employee or dependent is eligible for benefits from this Fund and is entitled to any similar benefits or services from any other plan or insurance (excluding a medical insurance policy owned and paid for by the member exclusively with his personal funds), such benefits under this Plan will be reduced to an amount, which, together with all other benefits will not exceed the actual cost of expenses incurred.

"Such Other Plan" is Defined to include:

Any other group insurance plan, or any other group hospital, surgical or medical benefit or service plan or any union welfare plan or other employee benefit plan for which the policyholder or any other employer has contributed to the cost thereof.

Which Plan Pays First:

To expedite the payment of claims when such duplicate coverage is involved, benefits will be paid under a Primary-Secondary concept. Primary means the plan paying first and Secondary means the plan paying second. When both plans contain the Coordination of Benefits provision, the plan that covers the person incurring the claim as an active employee shall be considered the Primary Plan.

If the claim is for a spouse and the spouse is entitled to such benefits under any other Plan, the spouse must first file for benefits under the Plan or source and then submit a copy of the benefits paid by that Plan to the Welfare Fund Office.

If a claim is filed for an eligible dependent child, the plan that covers the parent whose birthday occurs first in the year is the primary plan. However, where there is a duplication of group coverage and the other plan does not contain a Coordination of Benefits provision, the other plan shall be considered the primary plan.

Payment under the secondary plan is made after the amount payable under the primary plan has been determined. However, the total paid by all plans of coverage shall not exceed the total charges.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Benefits will be provided in accordance with the applicable requirements of a Qualified Medical Child Support Order. The process begins when the Plan receives a medical child support order (MCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

(a) Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;

(b) Requires a Participant to provide only the group health coverage available under the Plan for the Participant's Dependent children, even though the Participant no longer has custody; and

(c) Clearly specifies:

1. The Participant's name and last known mailing address and the names and addresses of each Dependent Child covered by the order,

2. A reasonable description of the coverage to be provided, and

3. The length of time the order applies,

The Plan will provide written notification to the Participant and each identified Dependent Child that it has received a court order requiring coverage. If the order meets the above requirements, the Plan will also provide written notification to the Participant and each Dependent Child that the order is a QMSCO and their eligibility for coverage. The foregoing is conditioned upon the order being filed on a timely basis and approved in writing by the Trustees.

The Qualified Medical Child Support Order cannot require the Plan to provide any benefit or option not otherwise provided under the Plan.

HOW TO CLAIM WELFARE FUND BENEFITS

When you or your dependents have a claim for benefits provided under the Allied Building Inspectors Local 211 I.U.O.E. Welfare Fund:

1. Call the Fund Office at (212) 233-2690.

2. The appropriate claim forms, with instructions, will be mailed to you.

3. Complete the claim form clearly and accurately. Be sure to have the doctor (in the case of Disability Benefits) or the dentist (in the case of Dental Benefits) or the chiropractor (in the case of Chiropractor Expense Benefits) or the podiatrist (in the case of Podiatry Benefits) complete the designated portion of the claim form.

4. Return the completed form to the Welfare Fund Office. Claims for disability benefits must be filed within 45 days after the date the disability commences, and supplemental forms must be filed promptly thereafter as requested by the Fund Office. All other claims must be filed within 180 days after the first day the claim is incurred for services rendered. Claims for Death or Accidental Death or Dismemberment Benefits must be filed within one year of the date of death or dismemberment. The Fund Office will validate your eligibility, and will issue a check for benefit amount to you; or in the case of your death, to your designated beneficiary.

CLAIMS REVIEW AND APPEAL PROCEDURE

The benefits provided by the Fund may be changed by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions in this booklet are subject to such rules and regulations and to the Trust Indenture which established and governs the Fund's operations.

All rules are uniformly applied by the Fund Office. The actions of the Fund Office are subject only to review by the Board of Trustees.

If your claim is denied in whole or in part, you will receive a written explanation, known as a "notice of adverse benefit determination," of the reason(s) it was denied and any information which may be needed to enable your claim to be reconsidered. If, after reading the explanation, you feel that the action taken on your claim may be incorrect, you should immediately ask the Fund Office to review your claim with you.

If you are still not satisfied with the action taken on your claim, you have the right to appeal the decision to the Board of Trustees. The appeal procedure is as follows:

1. Notify the Fund Office in writing within 60 days after you receive a notice of adverse benefit determination denial that you wish to have your claim reviewed by the Board of Trustees.

2. Include in your written request all the facts regarding your claim as well as the reason(s) you feel the original decision was incorrect. You will be given the opportunity to submit written comments, documents, records or any other matter relevant to your claim.

3. You will be provided, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

4. The administrator will present your written statement and other pertinent information to the Board of Trustees on your behalf.

5. You will receive the Board of Trustees' decision in writing either: (a) within 60 days after receipt of your written request for review; or (b) within 90 days if quarterly Trustees meetings are held. The written Notice will contain: the decision, reasons for

the decision and specific references to pertinent plan provisions on which the decision was based.

6. You may, at your own expense, have legal representation at any stage of these review procedures.

DISABILITY BENEFITS

For Employees

Disability Benefits shall be payable at the rate of $300 per calendar week, or $42.85 per work day, for periods of disability not earlier than the 15th calendar day of disability and continuing up to a maximum period of 26 weeks, commencing with the date on which the employee has exhausted all accumulated leave balances including but not limited to: sick and annual leave, compensatory time, administrative leave, and is off payroll completely, and is not eligible for benefits under Workers' Compensation or any similar provisions for occupational illness or accidental disability.

The maximum period of Disability Benefits shall be no more than 26 weeks for any one disability period. All payments under the Disability Benefits are subject to applicable Social Security Tax withholding.

Eligibility

To be eligible for Disability Benefits, the employee must be under the care of a physician, who shall certify on a claim form of the Fund that the employee is prevented by illness or injury from engaging in any employment.

Claims for disability benefits must be filed within 45 days after the date the disability commences and supplemental forms must be filed at least once per month, promptly thereafter, as requested by the Fund Office.

In case an employee is disabled but is not treated by a physician within the first 14 calendar days of his disability, benefits shall commence as of the first date of treatment by a physician for that disabling condition.

Successive periods of disability shall be considered as one period of disability unless the employee has returned to full-time active employment for two or more consecutive weeks.

In determining an employee's eligibility for Disability Benefits, the Fund shall have the right to require an independent medical evaluation of the

employee by a physician designated by the Fund. The cost of such examination shall be paid by the Fund. Failure or refusal of the employee to submit to such examination shall be cause for denial of Weekly Disability Benefits, and any other benefits normally provided by the Plan for employees and/or dependents during periods of the employee's disability.

NOTICE:

If at any time there is an overpayment by the Welfare Fund, it is incumbent upon the recipient to notify the Fund for an adjustment and make restitution.

This benefit shall terminate as of the date employment ceases.

DEATH BENEFIT

For Employees and Retired Employees

In the event of the death of an employee or retired employee for any cause, a Death Benefit shall be payable to the beneficiary or beneficiaries last designated by the employee or retired employee in writing, and on record with the Fund, according to the following schedule:

Employee Years of Coverage	**Amount**
2 months to **1** year	$ 2,000
1 year to **2** years	4,000
2 years to **3** years	6,000
3 years to **4** years	8,000
4 years or **more**	15,000
Retired Employees	5,000

In the event an employee becomes totally and permanently disabled prior to the attainment of his 60th birthday, and if such disability commenced while he was still an employee, his coverage for Death Benefits in the above amount shall be continued by the Fund without cost to the employee, except that this coverage shall terminate as of the effective date of the employee's retirement under the New York City Employees Retirement System.

You must apply for this continued Death Benefit coverage within one year after the onset of your total and permanent disability and submit appropriate evidence of such total and permanent disability.

The Fund may require the employee to submit proof at reasonable intervals of his or her continued total disability as a condition of continuation of

this coverage. Failure to submit such proof, or refusal to submit to a physical examination by a physician designated by the Fund, shall be cause for termination of this Death Benefit Coverage.

No Assignment:

The Plan does not recognize and will not accept the assignment of Death Benefits to any person or organization other than the beneficiary as designated in writing by the employee or retired employee and so recorded on the Plan's records.

In the event of the death of an employee who has failed to designate a beneficiary in the manner prescribed by the Fund, or in the event the designated beneficiary is deceased, the Fund shall pay the Death Benefit and/or Accidental Death Benefit as follows:

First: to the spouse, or if the spouse is not living,

Second: to the children, per stirpes, or if there are no children

Third: to the administrator or executor of the deceased employee's estate.

If the beneficiary is a minor or is, in the judgment of the Trustees, incapable of giving valid receipt for any payment due him, the Fund shall pay the benefits to the legally appointed guardian of such beneficiary, upon submission to the Fund of proof of such appointment.

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

For Employees

In the event of the death or dismemberment of an employee resulting from an accident, when such death or dismemberment occurs within 90 calendar days after the date of the accident, the following benefits, in addition to any other benefits which may be payable under the Plan, shall be paid to the beneficiary in case of the employee's death, or to the employee in case of dismemberment:

For Loss of Life……	**Scheduled Death Benefit**
For Loss of both Hands, or both Feet or Sight of both Eyes, or Loss of one Hand And one Foot, or one Hand or Foot and Sight or one Eye……	**Scheduled Death Benefit**
For Loss of one Hand or one Foot or Sight of one Eye……	**50% of Scheduled Death Benefit**

Only one benefit, not to exceed the maximum, payable on behalf of any employee for any accidental death or dismemberment under this provision.

Benefits under this section are not payable for losses resulting from war, bodily or mental infirmity, self-inflicted injury or suicide, disease or illness of any kind, or for losses in consequence of having committed a crime.

DENTAL BENEFITS

For Employees, Retired Employees and Eligible Dependents

Dental Benefits shall be payable to indemnify employees and retired employees for the expenses of dental care by a licensed dentist for employees, retired employees and their eligible dependents.

Under this Plan there is "no deductible" of covered dental expense which you are required to pay yourself before you qualify for benefits. Dental Benefits are payable for the first dollar of costs you incur for any covered dental procedure up to the amount set by the Funds Dental Fee Schedule. Members can use their own Dentist or a number of participating Dentists that accept the Participating PPO Schedule as full payment.

Participating Network of Dentists

You may choose any dentist of your choice. However, arrangements have been made with a Participating Network, Sele-Dent, which is willing to accept our schedule of benefits, with a few exceptions, as full payments for their services. You can find participating dentists on the Union's website (www.iuoe211.com), or visit www.Sele-Dent.com, and an additional list of participating providers may be located on the Local 211 Benefits page on the Sele-Dent web-site.

For Retirees a national network has been retained. Please call the Sele-Dent office at **1-800-520-DENTAL (3368)** to locate a Unicare participating provider in all states other than New York and New Jersey. You may need to pay a Unicare provider at the time of services rendered, and be reimbursed at 100% for covered dental services up to the Individual Annual Maximum.

Maximum benefits payable for any eligible individual under this plan shall be $2,000 per calendar year except Pediatric Coverage (up to age 19).

Services of $350 or more require prior approval and X-rays must be submitted with the forms. Procedures are subject to interpretation by our dental consultant.

Orthodontic Benefits

For Employees and Eligible Dependents
Up to 19 Years of Age

If a dependent under age 19 needs orthodontia that meets the definition of **Medically Necessary Orthodontics,** the benefit will be paid as follows:

Up to $2,000	paid at 100%
$2,000 to $4,000	paid at 40%
Over $4,000	paid at 20%

Orthodontic services that do not meet the definition of Medically Necessary Orthodontics will be covered up to a lifetime limit of $2,000.00.

Retainers are covered at a one-time payment of $400 with the exception of dependents under age 19, which will be covered at 100% up to $400, 40% for the next $400 and 20% thereafter.

Medically Necessary Orthodontics means the patient must have a **severe handicapping malocclusion.** This means the child's condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.

The determination will be made using a clinical evaluation using the Handicapping Labio-Lingual Deviations (HLD) Form to assess if the dependent has met the criteria. The minimum HLD score to be considered for approval of medically necessary orthodontic treatment is 28. The HLS assess the following:

- Upper and lower anterior impactions
- Ectopic Eruption
- Overjet

- Overbite
- Severe traumatic deviation
- Mandibular Protrusion
- Open Bite
- Posterior unilateral crossbite
- Labio-lingual spread
- Cleft palate deformities

No Orthodontic benefits will be provided for orthodontic appliances and treatments performed prior to your becoming eligible for this benefit. Benefits will be paid for treatments rendered after your eligibility date even though the orthodontic treatments commenced prior.

Limitations and Exclusions

In the event of termination of an employee's coverage, the Plan will provide Dental Benefits for Covered dental services which commenced prior to such termination and continuing for no longer than 60 calendar days after termination; provided, however, that a written description by the dentist for work in progress is submitted to the Fund Office within 15 days after termination of the employee's coverage.

Dental Benefits shall not be payable for services, procedures or series of treatments begun before the person became eligible for benefits; more than one examination or set of diagnostic X-rays, or two cleanings in any calendar year; dental services performed primarily for cosmetic purposes, except to remedy a result of accidental injury sustained while the individual was an eligible employee, retired employee or dependent, full or partial dentures, crowns or fixed bridgework which replace previous dentures, crowns or bridgework for which benefits were paid within the preceding **3** years by or through the Allied Building Inspectors Welfare Fund; tempo-mandibular joint treatment, nor for appliances which alter the bite, specialized appliances relating to partial dentures, implants; replacement of loss or stolen dentures or bridgework; changes for any dental procedures not listed on the above schedule.

Claim Submission

All Dental Claims should be mailed to:

Sele-Dent, Inc.
One Huntington Quadrangle, Suite 1S03
Melville, N.Y. 11743

Dental claims may also be submitted electronically.

For all Electronic Dental Claim Submissions:
Sele-Dent's EDI Payor # is **CX109**

Emergency Pre-Authorizations may be faxed to (516) 887-7896.

OPTICAL BENEFITS

For Employees, Retired Employees and Eligible Dependents

Optical Benefits consisting of payments up to a total maximum of $150.00, per eligible person shall be provided toward the costs of eye examination (for eye refractions only), prescribed eye glasses, prescribed lenses and eyeglass frames and contact lenses. This benefit shall be provided for an eligible employee, retired employee, or eligible dependent not more than once during any period of twelve (12) consecutive months. This period will begin at the first eligible date of optical expenses incurred by said person and at rate in effect at that date. For dependents under age 19, additional lenses will be provided if the child's prescription has changed.

For Eye Examination only..... $ 40.00

No benefit shall be payable for any services rendered by an Ophthalmologist, Optometrist or Optician for which the employee incurs no charge.

Optical benefits shall **not** include payment for sunglasses, plan or by prescription.

Participating Optical Company

You may choose any Ophthalmologist, Optometrist or Optician for your choice. However, arrangements have been made with a Participating Optical Company, General Vision Services which is willing to accept our schedule of benefits, with a few exceptions, as full payments for their services. You can find participating locations or obtain additional information concerning this arrangement from the Union's website (www.IUOE211.com).

HEARING EVALUATION AND HEARING AID BENEFITS

For Employees, Retired Employees and Eligible Dependents

Hearing Evaluation and Hearing Aid Benefit shall be payable to indemnify employees and retired employees for expenses incurred for providing a hearing evaluation and a hearing aid, if prescribed upon the basis of the hearing evaluation. These benefits will be provided to an eligible employee, retired employee or eligible dependent not more than once curing any period of twenty-four **(24)** consecutive months in accordance with the following schedule:

Hearing Evaluation	$ 25.00
Hearing Aid	$1,500.00

Arrangements have been made with a provider network, General Hearing Services which can provide services for little or no out of pocket costs to you. You can find participating locations or obtain any additional information concerning this arrangement from the Union's website www.IUOE211.com.

CHIROPRACTOR EXPENSE BENEFITS

For Employees, Retired Employees and Eligible Dependents

Chiropractor Expense Benefits shall be payable for expenses incurred for treatments by a chiropractor up to $25.00 per visit, with a maximum of 24 visits per calendar year, provided the chiropractor is licensed by the state in which he/she practices and indicates his/her license number on claim forms submitted for payment. Eligible expenses shall include reimbursement of co-payments for chiropractor treatments.

PODIATRY BENEFITS

For Employees, Retired Employees and Eligible Dependents

Podiatry Benefits shall be payable for expenses incurred for treatments by a podiatrist up to $25.00 per visit with a maximum of 12 visits per calendar year, provided the podiatrist indicates his/her license number on claims forms submitted for payment. Eligible expenses shall include reimbursement of co-payments for podiatry treatments.

PRESCRIPTION DRUG BENEFITS

For Employees, Retired Employees and Eligible Dependents

Prescription Drug Benefits are provided for employees, retired employees and their eligible dependents for the cost of Prescription Drugs, subject to a deductible charge for each prescription or refill of a prescription. You will receive a prescription drug identification card. The card will have the members name and group number on it. You will be able to use the card at most pharmacies throughout the country. The co-payment is the greater of $5.00 or 20% of the cost of generic and preferred brand drugs and 40% of the cost of non-preferred drugs. The Prescription Drug Benefit year is January 1 to December 31. The first $4,000 in benefits per family, is subject to co-payments above, the next $4,000 is subject to 50% co-insurance (the plan pays 50%) and the plan pays 25% for any coverage over $8,000 per family.

Your doctor may prescribe up to two months of drugs, one **34** day supply, one refill, for any one prescription to be filled by your local pharmacy. If your doctor wishes to prescribe more than a 34 day supply, you should follow the procedures outlined in the next paragraph for the Mail Order Program. Prescriptions for chronic medications should also be filled through the Mail Order Program.

Mail Order Program: Enables you to utilize our Direct Mail Service Pharmacy. You will be entitled to receive up to a 60 day supply for your medication when prescribed by your physician with one refill, if authorized, for another 60 day supply. You will be responsible for a co-payment for the original prescription and the authorized refill. The co-payment is $5.00 for a **"Generic"** drug, $10.00 for a **"Preferred Brand"** and $25.00 for a **"Non-Preferred Brand"** (subject to the co-insurance over $4,000 mentioned above).

In the event an employee, retired employee or eligible dependent secures and pays for a covered prescription drug through a non-participating pharmacy, the employee may submit a claim to the current Prescription Drug Benefits Administrator and be eligible for reimbursement. Such reimbursement shall be either the amount which would have been paid on behalf of the Fund had the prescription been billed by a participating pharmacy, or the actual prescription charge, minus the applicable deductible, whichever is less.

Dependent children are eligible up until their twenty-sixth (26) birthday. Prescription Drugs covered by this Plan are those medications which may be legally dispensed only on the prescription of a licensed Medical Doctor,

Dentist or Osteopathic Physician. Also covered are prescriptions which must be compounded by the pharmacist.

Prescription smoking deterrent drugs will be covered only once, for a maximum of 3 months, for each employee, retired employee and eligible dependent. The plan does not cover oral contraceptives or drugs which legally can be dispensed without a prescription, such as aspirin, even though the doctor may have prescribed these. Also excluded are hypodermic syringes and needles and other non-drug items such as vitamins, even when prescribed by a physician. Also not covered are injectable and items that can be purchased over the counter.

There are several programs that have been instituted to maximize the value of our Prescription drug benefit and lower prescription costs to protect the Fund. Not all drugs are required to adhere to these programs, your pharmacist will let you know when you pick up your prescription. These are:

- **Step Therapy Program** that requires you to first try a more cost-effective medication (typically generic) that has proven effective for most people with a condition before you can receive a more expensive brand name medication.

- **Prior Authorization Program** for medications which have a higher possibility of overuse or may be prescribed outside of clinical dosing guidelines.

- **Quantity Limit Program** for medications which have a higher possibility of overuse or may be prescribed outside of clinical dosing guidelines.

SCREENING BENEFITS

For Employees (age 31 or above)

Screening Benefits are offered through Inner Imaging, P.C. ("Inner Imaging"). Employees, age 31 or above, are eligible for one screening every five (5) calendar years for a co-pay of $187.50 at the time of the screening. Screenings consist of four, individual, radiological tests of the heart, lungs, abdomen, and pelvis. Inner Imaging will provide radiological interpretations of the four tests and make recommendations for additional services when necessary. Follow-up lung exams will be offered when necessary at a rate of $150. Inner Imaging will provide participants information regarding whether any additional services are covered.

Inner Imaging is located at 165 East 84th Street, New York, NY 10028, and Employees can schedule a screening by phone at 212-777-8900.

PREPAID LEGAL SERVICES PLAN

For Employees, Retired Employees and Eligible Dependents

HOW TO RECEIVE LEGAL SERVICES

An appointment for a private consultation with an attorney may be made by calling the law offices of Stuart Salles, ESQ at (212) 267-9090.

You will receive an appointment as soon as possible at the law office of Stuart Salles, 225 Broadway, Suite 1900, New York, NY 10007.

LEGAL SERVICES TO BE PROVIDED UNDER THE LEGAL SERVICES PLAN

- Consultation
- Legal advice and research
- Drafting of wills, powers of attorney, health care proxies, medical directives and simple revocable trusts
- Prenuptial agreements
- Separation agreements
- Divorces
- Family court custody, visitation and child support
- Adoptions
- Change of name
- Purchase or sale of residence
- Representation of tenant in landlord tenant matters
- Defense of certain civil litigation
- Retail credit and other consumer contracts
- Consultation only in immigration matters
- Traffic violations resulting in loss of license

Coverage is limited to the State of New York, in New York City, Nassau County, Suffolk County, Westchester County, Rockland County, Orange County, Dutchess County, State of New Jersey, and State of Connecticut. Coverage is limited to 25 hours in a plan year, after which, services will be billed at the reduced rate of $100.00 per hour.

EMERGENCY APPOINTMENTS

If a real emergency exists, explain the situation when you call (212) 267-9090. If you are eligible, and the service is one covered by the Plan, you will be given an appointment early enough to take care of the emergency.

WHAT ARE THE COSTS TO THE EMPLOYEE?

If there is Court, witness examination, stenographic, extraordinary mail, travel, printing, filing fees or fines, these are to be paid by the member to the attorney. These are the only costs to you within the 25 hours of coverage.

CONFIDENTIALITY OF PROBLEMS

All services rendered to you by the staff of the law firm will be kept in strictest confidence. Communications with the attorney and the law firm are within the attorney client privilege.

All legal services and matters not specifically listed as a covered service or matter are not included within the Plan and eligible members will not be entitled to any service not included.

PRIVACY RULES

This section describes how medical information about you may be used and disclosed by the plan and how you can get access to this information. Please Review It Carefully.

Under federal law group health care plans are required to notify participants and beneficiaries in a group health plan about how the plan will use and disclose "individually identifiable health information" (described below) which it maintains on your behalf. The federal requirements are set forth in the Health Insurance Portability and Accountability Act of 1996 or HIPAA.

"Individually identifiable health information" is also referred to in the law as "protected health information" or PHI. It includes:

> …information maintained by a health care provider, health plan, employer, or health care clearinghouse which relates to past, present, or future physical or mental health or condition of an individual…that identifies the individual or to which there is a

reasonable basis to believe the information can be used to identify an individual.

HIPAA requires that your group health plan maintain the confidentiality of PHI in accordance with federal regulations. HIPAA also requires the Plan to notify participants and beneficiaries about their privacy rights which is the purpose of this office. The Trustees of your Plan urge you to read this section cover-to-cover so that you are fully aware of your privacy rights.

The use of the word "you" in this section refers to individual participants and beneficiaries in the Plan such as yourself. To make reading this notice easier, certain abbreviations are used such as: PHI-protected health information, and GHPs-group health care plans. Occasionally a reference is made to a specific section in the applicable federal regulations; the full text of these sections may be obtained from the Fund Office.

Use of PHI Without Your Consent

Under the federal privacy law and related regulations, the Plan is permitted, and in some cases required, to use and disclose your PHI without your consent or authorization for the following purposes:

1. Your health care treatment;
2. Processing and payment of your health care claims; and
3. Health care operations.

Treatment. A service provider will often need to check with the Fund Office to make sure you are eligible for coverage or a service provider may need to know from the Plan who has treated you previously and what the earlier diagnosis was and what treatment was prescribed. The Plan is permitted to provide such PHI to the service provider without your consent.

Claims Processing and Payment. The Plan usually receives a bill from each service provider who treated you (e.g., hospital, physician, lab, clinic, etc.) containing a diagnostic code and a treatment code for a specific patient. This is PHI. The Plan uses this information to process the claim on the computer and to generate a check for the appropriate payment of the service provider in accordance with the Plan's rules.

Health Care Operation. The Plan often uses PHI for case management of specific patients (such as diabetics, heart patients, cancer patients, etc.), providing insurance carriers with data needed by the carrier to quote premiums to the Plan, reviewing the competence or qualifications of

various health care providers, utilization review where alternative treatment options are available, and detection of fraud and abuse.

When the Plan provides PHI to another entity for any of the purposes listed above, the Plan will make reasonable efforts to limit the PHI provided to the "minimum necessary", as that term is defined in Section 164.502(b) of the final privacy rules.

Other Purposes For Which Your PHI May Be Used Without Your Consent

In addition to the purposes described above, there are a number of other purposes for which the Plan may use or disclose, or may be required to disclose, your PHI without obtaining advance consent or authorization from you. These include (but are not limited to):

1. Responding to public health agencies authorized by law to collect or receive health information for the purposes of preventing or controlling disease, injuries, or disabilities.

2. Responding to public health agencies or social service agencies or protective service agencies authorized by law to receive reports of child abuse, neglect, or domestic violence.

3. Responding to an employer's request if the employer needs to know if his employee has suffered a work-related illness or injury and is entitled to worker's compensation.

4. Responding to the trustees' request for PHI if the trustees need such information for review of a denied claim or for an assessment of a Plan's benefit costs by type of health care service provided.

5. Responding to a request from a health oversight agency authorized by law to conduct audits; civil, administrative, or criminal investigations; inspections; licensure or actions against health care providers; or other activities designed to protect the health care system.

6. Responding to inquiries from law enforcement agencies that require reporting of certain kinds of wounds or physical injuries or to assist with the identification or location of a suspect, fugitive, material witness, or missing person.

7. Responding to inquiries from correctional institutions or lawful official having custody of an inmate if the PHI is necessary to

protect the health of the inmate or other inmates and employees at the correctional institution.

8. Responding to requests from health research agencies, whether privately funded or funded by the government. (However, use of PHI by a research agency is closely monitored by other review boards and is subject to a complex array of other federal regulations.)

Use or Disclosure of PHI Requiring Your Authorization

Except as otherwise permitted or required above, the Plan may NOT use or disclose any PHI without your authorization.

For example, if you are being treated for a mental illness, the Plan is NOT authorized to release any psychotherapy notes related to your case without your consent. The Plan is permitted, however, to use PHI related to your treatment or processing of your claim for mental health services without your consent (except for the psychotherapy notes).

If you wish to authorize the release of psychotherapy notes or any other PHI requiring your consent, contact the Fund Office for a disclosure authorization form. The form will ask you what PHI may be disclosed, who may receive designated PHI, when the authorization expires, and indicate your right to withdraw the authorization under certain conditions.

Your Rights Regarding Access To Your Own PHI

Put restriction on use and disclosure of PHI.

You may request that restrictions be placed on the uses and disclosure of your PHI for treatment, payment of claims or health operations in accordance with Section 164.522(a) of the privacy rules. Your request must be submitted to the Fund Office in writing.

The Plan is NOT required to agree to a requested restriction if the Plan needs your PHI for treatment, payment of claims, or health operations. Even if the Plan accepts your restriction, the Plan may be required to release such information for emergency treatment, law enforcement, or other purposes specified by state and/or federal laws.

You may terminate a restriction at any time, either orally or in writing. Otherwise, the Plan will keep the restriction in effect for up to six years after it is first filed.

Inspect or copy your PHI.

You may ask to inspect or to copy your PHI found in a "designated record set". A "designated record set" is: (1) the medical records and billing records maintained by the Plan about each participant or by a health care provider; and (2) enrollment, payment, claims adjudication, and case management records maintained by the Plan or individual participants and beneficiaries. Generally, the Plan will not have detailed medical records but will have computer coded data needed to process a claim submitted by a health care provider.

If you wish to examine or copy a designated record set, the request must be in writing on a form provided by the Plan. The Plan will arrange a convenient time and place for you to inspect and/or copy the PHI requested. The Plan will discuss with you in advance the scope, format, and other aspects of the request in order to facilitate the timely provision of the requested PHI. Access will be provided within 30 days after the request is first received by the Fund Office (unless the PHI is not readily available at the Fund Office in which case a 60-day time limit applies).

If the Plan denies you access to your own PHI, you will receive a written denial explaining the reasons for the denial and the procedures to be followed if you wish the denial to be reviewed by the Trustees.

If you want copies of the PHI, there will be a charge based on the cost of reproduction and for postage if you want the copies mailed. The Plan will tell you what these charges are before copying begins.

Amend your PHI.

You have the right to amend your own PHI if you believe it is inaccurate or incomplete in accordance with the procedures set forth in Section 164.524 of the privacy rules.

The request must be submitted in writing on a form provided by the Plan. The Plan will respond to your request for correction of your PHI within 60 days after receipt of your request. If approved, the Plan will notify other parties (such as health care providers or clearinghouses) about any corrections in your PHI if necessary to prevent any subsequent actions which may be detrimental to your health care.

If the change is disapproved by the Plan, you will be notified in writing about the reasons for denial of your request, about your right to disagree with the denial, and about the appeal procedures. A participant may request that his letter of disagreement be included with any future disclosure of his or her PHI.

Designate address to receive information regarding your PHI.

You have the right to designate an address, other than your home address, at which to receive claims-related information or other PHI, involving yourself or your dependents, from the Plan.

Request accounting of PHI disclosures requiring consent.

You have the right to request an accounting of any disclosure of your PHI made by the Plan if you consent or authorization was required for such disclosure.

The disclosure will include: the date of the disclosure, the name and address of the entity or person to whom your PHI was disclosed; a brief description of the PHI disclosed; and the reason for the disclosure or a copy of your signed authorization for the disclosure. The Plan will provide this information within 60 days after your request is received by the Fund Office.

Access Of Parents To The PHI Of Their Children

Under the privacy rules a parent usually acts as a "personal representative" of his or her child. As a result, parents generally have authority to access or to amend his or her child's PHI. However, there may be exceptions under state law or other law. For example, some states do NOT require consent of a parent or other persons before a minor can obtain a particular health care service (such as mental health treatment). Or, a court my grant authority to make health care decisions to an adult other than the parent. These are issues best discussed with your own attorney if the need arises.

What The Plan Is Prohibited From Doing Without Your Authorization

The Plan or any entity performing services for the Plan (such as an insurance company or third party administrative firm) is NOT permitted to give or sell lists of patients or enrollees to a telemarketer, door-to-door salesman or other entity unless that entity has agreed by contract with the Trustees of your Plan to use the information only for informing you about the health care services and/or supplies provided by the Plan.

If the Plan markets particular goods and services to participants, the Plan is required to identify itself as the party making the communication, indicate whether the Plan has received or will receive direct or indirect remuneration for making the communication, and except when the communication is contained in a newsletter or other general communication to all participants, offer you the opportunity to opt out of receiving any future marketing information.

The Plan is also permitted to use or disclose PHI to identify participants in a particular target group to receive marketing information based on their health care status or conditions (e.g., a communication intended for all diabetics or for all arthritic patients) as long as the communication clearly states why you have been targeted and how the product or service relates to your health. You may opt out of receiving any further communications directly related to your health condition by contacting the Fund Office.

Plan's Right to Change This Privacy Notice

Until further notice the Plan will maintain the privacy of your PHI in accordance with the rights and requirements set forth in this notice. However, the Plan reserves the right to change the terms of this notice at any time and to make the new notice effective for PHI that it maintains.

Any revised notice will be distributed to individuals via first class mail at least 30 days before the effective date of the new notice.

Need Help?

If you have any questions about this privacy notice or your privacy rights, contact the Fund Office. Please address your inquiry to the Fund's privacy officer.

We hope this booklet has provided you with the most important information about your Plan. If you have any questions about your Plan, you should contact the Board of Trustees at:

ALLIED BUILDING INSPECTORS
Local 211, I.U.O.E. Welfare Fund
225 Broadway, 43rd Floor
New York, NY 10007

or phone the Fund Office at (212) 233-2690

Office hours are 8 a.m. to 4 p.m.
Monday - Friday

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