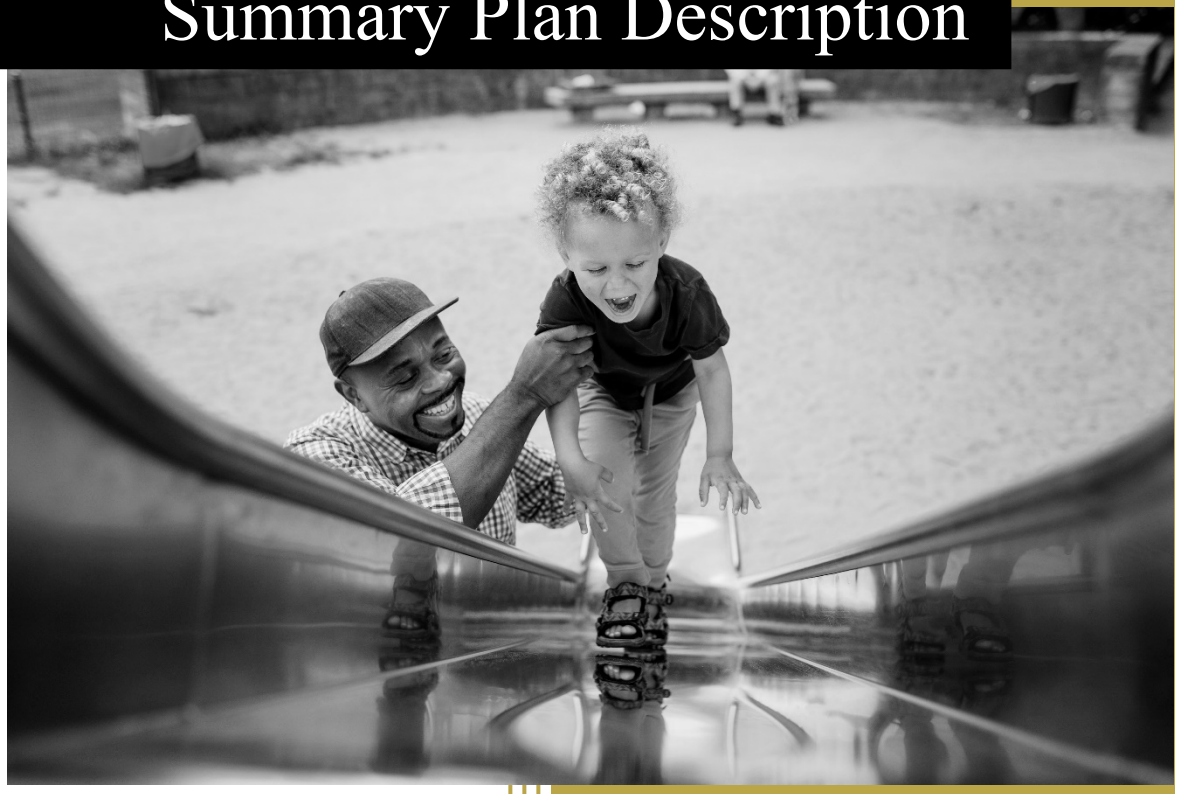
2024

BAC LOCAL 8 NY WELFARE PLAN
Summary Plan Description



BAC Local 3 NY

Ithaca Chapter Benefits

1/1/2024

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INTRODUCTION

Dear Participants and Beneficiaries,

The Bricklayers Local 8 NY Health Fund Board of Trustees is pleased to provide you with this revised benefit booklet. You should read all parts of this booklet carefully to become familiar with your rights, duties, and responsibilities so that you and your dependents may utilize these benefits when needed.

You must apply for all benefits. Please be sure the Fund Office has your current address, the current address of your dependents, and your death beneficiary designation on file.

On January 1, 1975, The Employee Retirement Income Security Act of 1974 (ERISA), became applicable to benefit plans of this type. Accordingly, this booklet constitutes your Plan description, and you should pay special attention to the pages that describe your eligibility, termination of eligibility, and claims procedures.

This booklet and the Fund Office personnel are available to you for information about the Plan. All reimbursements are conditional upon eligibility on the date services are rendered and are subject to all Plan limitations. The Trustees have the final authority to accept or reject any recommendations made to the Plan by the Fund Office. You will be notified of any changes made by the Trustees or as mandated by law.

It is the intention of the Trustees to continue the Plan indefinitely to provide the maximum benefits allowed by the collectively bargained contributions received by the Board of Trustees. However, please note that the Trustees reserve the right, within their sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all the provisions of this Plan (including without limitation any benefits to retirees, related Plan documents and underlying policies), at any time and for any reason.

If you have further questions about the Plan after reviewing this Summary Plan Description, please contact the Fund Office Monday through Friday at 607.272.3853, via email at ashleyt@bac3ny.com, or write to: 701 West State St., Ithaca, NY 14850. You may also find information regarding the plan on our website, www.bacithaca.com.

GENERAL INFORMATION

Plan Administrator

Name of Plan: International Union of Bricklayers and Allied Craftsmen Local 8 NY Welfare Plan

EIN: 16-6058900.

Plan No.: 501

The Plan is sponsored by the Board of Trustees of the International Union of Bricklayers and Allied Craftsmen Local 8 NY Welfare Plan. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund. The names and addresses of the Trustees are as follows:

Employer Trustees

Bradley Walters
Builders Exchange of the Southern Tier
15 Belden St.
Binghamton, NY 13903
716-474-7596 (cell)
brad@bxstier.com

Frank Martino Jr.
Martino Tile Inc.
8 Karla Drive
Windsor, NY 13865
607-727-4112
frankjr@martinotile.com

Jay Niedzialkowski
Alliance Masonry
2544 State Rt. 12
Chenango Forks, NY 13746
607-639-1665
607-267-6850 (cell)
jniedz@alliancemasonrycorp.com

John Healy (Alternate)
Builders Exchange of the Southern Tier
65 East Main St
Falconer, NY 14733
740-381-0396 (cell)
john@bxstier.com

Union Trustees

Brian Edwards
Streeter Associates
101 East Woodlawn Ave
Elmira, NY 14902
607-857-0963 (cell)
bedwards@streeterassociates.com

Justin Summerfield
Southern Tier Training Coordinator
4 Railroad St
Whitney Point NY 13862
607-222-8010 (cell)
justins@bac3ny.com

Thomas J Brown II (alternate)
Alliance Masonry
2544 State Route 12
Chenango Forks, NY 13746
315-794-0471
Tj.brown@yahoo.com

No one except the Board of Trustees (and other Plan fiduciaries and individuals or entities, including any insurance company, to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without

limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Fund or the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

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

Ashley Tilebein
Fund Administrator
701 West State St.
Ithaca, NY 14850
P: 607.272.3853
F: 607.272.2966
atilebein@baclocal3ny.com

The Fund Administrator also keeps the records for the Fund. The Board of Trustees has authorized the Fund Administrator to respond in writing to any questions you may have about the Fund. As a courtesy, the Fund Administrator may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot be relied upon in a dispute concerning your benefits. If you have an important question, you should contact the Fund Administrator for a written response. Keep in mind, however, that the official Plan documents (which include this booklet) always govern even if they are inconsistent with advice you receive.

Service of Legal Process

The name and address of the Fund's agent for service of legal process is:
International Union of Bricklayers and Allied Craftsmen Local 8 NY Welfare Plan
701 West State St.
Ithaca, NY 14850
Legal process may be served on the Plan Administrator or any individual Trustee.

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

upon written request, information as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

Type of Plan

The Plan is a welfare benefit plan providing health, hospitalization, health care reimbursement, life insurance, and paid time-off benefits. The health and hospitalization benefits are insured through an insurer or health maintenance organization. Other benefits are provided on a self-insured basis.

Fully Insured Group Health Insurance Details (Active Participants and Under 65 Retiree Coverage)

Carrier: Excellus BlueCross BlueShield

Name of Plan: BAC Local 8 NY Welfare Plan

Claims Department: Excellus BCBS Claims Department
PO Box 21146
Eagan, MN 55121

Website: www.excellusbcbs.com

Customer Care: 1-800-499-1275

Group Number: 001126900001

Coverage Year: January 1st- December 31st

Medical Health Reimbursement Account Details (Active Participants and Under 65 Retiree Coverage)

Administered by: Lifetime Benefit Solutions

Name of Plan: BAC Local 8 NY Welfare Plan

Claims Department: Lifetime Benefit Solutions Claims Department
PO BOX 211126
Eagan, MN 55121

Website: www.lifetimebenefitsolutions.com

Customer Care: Please Call the Fund Office at 607-272-3853

Coverage Year: January 1st- December 31st

Dental and Optical Health Reimbursement Account Details (Active Participants only)

Administered by: Lifetime Benefit Solutions

Name of Plan: BAC Local 8 NY Welfare Plan

Claims Department: Lifetime Benefit Solutions Claims Department
PO BOX 211126
Eagan, MN 55121

Website: www.lifetimebenefitsolutions.com

Customer Care: Please Call the Fund Office at 607-272-3853

Coverage Year: January 1st- December 31st

Group Death Benefit Details

Administered and funded by: International Union of Bricklayers and Allied Craftsmen Local 8 NY Welfare Plan

website: www.bacithaca.com

Customer Care: Fund Office 607-272-3853

Coverage Year: January 1st - December 31st

Medicare Advantage PPO Plan + Prescription Drug Plan (Medicare Eligible Participants)

Carrier: Humana

Service Provider: RetireeFirst

Name Of Plan: BAC Local 8 NY Welfare Plan

Insurance Plan Name: Humana Medicare Advantage with Prescription Drug (MAPD) Plan

Claims Department: Call the RetireeFirst Customer Care Hotline

website: www.retireefirst.com

Customer Care: (607) 258-9158 (TTY 711) or (866) 280-5793 (TTY 711) Monday-Friday, 8am-5pm EST

Group Number: 330150

PLAN SYNOPSYS

The BAC Local 8 NY Welfare Fund's group health insurance plan, for Active Members and Retirees under 65, is a High Deductible Health Plan (HDHP) through Excellus BlueCross BlueShield, combined with a Health Reimbursement Arrangement (HRA), administered by Lifetime Benefit Solutions.

A HDHP offers low insurance premiums with a high annual deductible that must generally be met before you receive benefits for covered services. A limited number of benefits, including preventive services, are not subject to the deductible. Refer to the certificate of coverage for a complete description of the plan's coverage. At the time of enrollment, you will receive a benefit summary. To receive maximum benefits, you must comply with the terms and conditions of the insurance contract or certificate of coverage.

A Health Reimbursement Arrangement *(HRA)* is an Internal Revenue Service (IRS) sanctioned employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums. Using an HRA yields tax advantages to offset health care costs for both employees as well as employers. Each covered individual must meet an individual deductible of $300 per plan year or a family deductible of $600 before they are eligible for HRA reimbursements. The HRA then reimburses the member 70% of the medical carrier's remaining in network expenses. The HRA only reimburses for claims submitted to your group medical insurance.

The Plan also includes a dental and vision HRA benefit for Active members. Individuals covered under the Plan will receive a VISA health spending card to pay for eligible dental and vision services and materials. Each person has an annual maximum of $800 to use for the Plan Year. You must keep all receipts and you may use your card only for your own expenses. You may not use your card for any other individual's expenses. Unused balances do not roll over. This benefit is not offered to Retirees.

Qualifying Retirees over age 65 are eligible for the Medicare Advantage PPO + Prescription Drug (MAPD) Plan, which includes Medicare Part A, B, and D. There are no medical coinsurance, co-pays or deductibles under this plan and Referrals are not required. There are co-pays for prescription drugs and in some cases authorization may be necessary.

To accommodate for New York State's Paid Sick Leave Law, BAC 3 NY and the various Employer Associations have negotiated into the 2022-2025 Collective Bargaining agreement a comparable benefit of $1/hour. Your Wage Replacement Account will provide you with taxable paid time off or vacation benefits.

DEFINITIONS

Throughout this SPD, the following terms and definitions apply:

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

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

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

The term **"Employer"** will mean (i) any one of the employer members of an employer association that enters into a Collective Bargaining Agreement with the Union; (ii) an independent signatory to a Collective Bargaining Agreement that is acceptable to the Board of Trustees; (iii) the Fund itself; (iv) the Union; and (v) any signatory to a participation or other agreement requiring payment of periodic Contributions to the Fund by such person or entity that is acceptable to the Board of Trustees.

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

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

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

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

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

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

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

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

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

ACTIVE PARTICIPANT ELIGIBILITY AND ENROLLMENT

How do I become eligible?

You must work 1200 hours under Covered Employment during the Eligibility Year (Oct 1- Sept 31)

Self-Pay Contributions –Once eligibility requirements have been met in a prior Eligibility Year, an active Employee who has worked at least 300 hours is permitted to pay the difference between 300 hours and 1200 hours at the current hourly contribution rate. The Board of Trustees allows the Employee to make the payment in 1, 2, 4 or 12 installments, whichever fits your financial situation.

New Employee Self-Pay Options – If a newly hired Employee works at least 250 hours or more in a three-month period he/she will be eligible to self-pay for Medical only coverage at 100% of the current premium effective on the first month after they have worked 250 hours. No HRA reimbursements, dental and optical coverage will be available. Coverage under this provision will last until the end of the current Benefit Year (December 31st), at which time they will be eligible for COBRA coverage.

If a new Employee has worked less than 1200 hours in Covered Employment in an Eligibility Year but has worked at least 500 hours in an Eligibility Year, the Employee is eligible to purchase coverage at the current hourly contribution rate. HRA reimbursements, dental and optical coverage are included in this coverage. The Board of Trustees allows the Employee to make the payment in a lump sum or 12 installments, whichever fits their financial situation. Payment is due to the Funds office on the last business day of the month for the following month's coverage.

If a new Employee does not opt to self-pay or does not qualify for self-pay by the end of the first full Eligibility Year immediately following initiation (they did not reach 500 hours), he/she must work 1200 hours during a future Eligibility Year to be eligible for coverage under the Plan.

An employee's eligibility to participate in the Plan requires continued employment with the employer and is subject to the terms and conditions of the plan document, insurance contract, and certificate of coverage. These options are only available to new Employees. Any Employee that has had prior coverage under the Plan at any time will not be eligible.

In addition, new Employees must notify the Fund office and complete the required paperwork to be eligible.

How do I Enroll?

During the annual open enrollment period of November 1st through December 20th, benefits-eligible Employees may elect or waive coverage in the Plan as well as add or drop coverage for eligible dependents.

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

How long does coverage last?

The Coverage year is January 1st- December 31st of the year following the qualifying eligibility year.

Who can be covered?

- Your legal spouse (includes same or opposite sex spouse), unless you are divorced, or the marriage has been annulled.
- A natural, step, legally adopted, or foster son or daughter. Coverage continues until the end of the month in which the child turns age 26. Note: The child does not need to be a full-time student, unmarried, financially dependent on the employee, claimed as a dependent on the employee's tax return, or a resident of the employee's household.
- Domestic partner; ask the Fund Office for the proof of domestic partnership packet.
- Unmarried children of any age if:
  - They are unable to work or support themselves because of mental illness, developmental disability, or mental retardation, as defined in applicable state law or because of physical handicap; and
  - They became incapacitated before reaching the age at which coverage as a dependent would otherwise have been terminated under the group plan.

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

The insurance carrier and plan the administrator reserve the right to request proof of an individual's dependent status.

Young Adult Coverage to Age 29

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

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

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

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

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

How do I add or remove a covered dependent?

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

- Addition or loss of a spouse through marriage, death, divorce, annulment, or legal separation.
- Addition of a dependent through birth or adoption.
- Gaining a stepchild or becoming legal guardian of a child.
- A dependent child has a change in, or loss of, dependent status under the plan; or
- Receiving a qualified medical child support order (MCSO).
- End of a domestic partnership (refer to the insurance contract and certificate of coverage for the definition of a "domestic partner")

Complete the dependent change from which you can find on our website www.bacithaca.com or by request from the Fund Office, within 30 days of the change in status. If you fail to enroll or cancel your own or a dependent's coverage within the required time frame, you will normally have to wait until the next open enrollment period to make any benefit election changes.

Can I lose coverage?

Yes. If an Employee fails to make an installment payment, his/her coverage will be terminated, and the Employee will be required to re-qualify with 1200 hours worked in a future Eligibility Year.

Termination of Coverage

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

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

Do I have a choice in participating in the plan or not?

Yes. If you qualify, but have coverage elsewhere, you may choose not to be enrolled in the BAC Local 8 NY Group Health plan by selecting that option on the Enrollment form. Choosing this option requires you re-qualify with 1200 hours worked in a future Eligibility Year and counts as a break in coverage for retirement rules. Benefit contributions are assets of the Fund and cannot be paid out.

PLAN DETAILS

The Plan encompasses many different parts. Below are details of the benefits which make up the Plan in its entirety.

EXCELLUS BLUE PPO

What type of Plan is this?

This is a fully insured High Deductible Health Plan providing medical and prescription benefits through a contract with the carrier. The Excellus Group Contract will control in defining the specific benefits to which you and your covered Dependents are entitled including any deductibles, co-payments, lifetime or annual caps, network providers, and any other conditions or limitations on benefits. You will be provided with an insurance benefit booklet, which provides a detailed description of your benefits directly from the insurance company and you may obtain additional copies, free of charge, from the Fund Office.

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

What is a High Deductible Health Plan?

A HDHP offers low insurance premiums with a high annual deductible that must generally be met before you receive benefits for covered services. A limited number of benefits, including preventive services, are not subject to the deductible. Refer to the certificate of coverage for a complete description of the plan’s coverage.

What does it cover?

This Plan provides coverage for prescription drugs, health care, and hospitalization according to the insurance carrier's certificate of coverage.

Can I choose my provider?

The plan provided is a PPO, or Preferred Provider Organization. A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network.

My Provider won't bill my insurance, what do I do?

In some instances, your out of network provider may ask you to pay up front and will not submit your claim to your insurance. If this happens you will need to manually file your claim to the carrier by completing the Excellus claim form which can be found on our website, or by request from the fund office.

Do I have to pay out of pocket for preventive care?

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

Can I "max out" my coverage?

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

What is an Out-of-Pocket Maximum?

There is an out-of-pocket maximum that each member must pay out-of-pocket (e.g., deductible, coinsurance, copayments) for covered benefits per plan year. Once this dollar amount is reached, the Medical Insurance Carrier pays your covered benefits in full for the remainder of the plan year. Each member is responsible for 30% of his or her own out-of-pocket maximum, the remaining 70% is reimbursed by the HRA.

Do I need prior authorization for services?

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

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

Coverage When Traveling Outside the Service Area

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

Emergency Care

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

HEALTH REIMBURSEMENT ARRANGEMENT (MEDICAL HRA)

What is an HRA?

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

How is the HRA Funded and Paid?

The HRA is funded through Employer Contributions and the general assets of the BAC Local 8 Welfare Fund. The HRA account is a record-keeping account maintained on your behalf to keep track of the amounts available for reimbursement of eligible expenses. Please note that the Plan Administrator will not establish a separate bank or investment account to hold Employer contributions. Actual segregation of assets does not occur.

How do I request reimbursement for a medical claim from the HRA?

When you seek care from a health care provider, they will send a claim to the Medical Insurance Carrier. Once processed that claim will automatically be sent to your HRA Administrator. Each subscriber must meet an individual deductible of $300, or a family deductible of $600, per plan year before they are eligible for HRA reimbursements. The HRA then reimburses the provider 70% of the medical carrier's remaining in network out of pocket expenses. The HRA only reimburses for claims submitted to, and covered by, your group medical insurance.

How do I request reimbursement for a prescription from the HRA?

When you fill a prescription at a participating pharmacy, you will pay the negotiated amount. The pharmacy will send the claim to your insurance carrier. Once processed that claim will automatically be

sent to your HRA Administrator. Each subscriber must meet an individual deductible of $300, or a family deductible of $600, per plan year before they are eligible for HRA reimbursements. The HRA then reimburses the member 70% of the cost of the prescription. The HRA only reimburses for claims submitted to your group medical insurance. *(Note: both in and out of network claims can be reimbursed under the HRA.)*

What if I was reimbursed too much money?

If you are overpaid for a claim for any reason, you must notify the Fund Office and refund the HRA administrator the amount of overpayment. Knowingly accepting unauthorized benefits is considered insurance fraud. Fraud is considered a federal crime, with imprisonment lasting up to 10 years. Fines can be significant varying from $10,000-$50,000 per charge of fraud healthcare practices. Overpayments often happen because of payment by another insurance plan such as that of a spouse.

DENTAL AND OPTICAL BENEFITS

How much is the Dental and Optical Benefit?

When you enroll in the BAC Local 8 Health Plan you and your dependents each receive $800 pre-loaded onto a VISA Health Spending Card to pay for covered Dental and Vision services.

What can I use this benefit for?

To be reimbursable, an eligible health care expense must meet all of the following requirements:

- The expense must be for medical care as defined in Section 213(d) of the Internal Revenue Code and is not eligible for reimbursement under any other plan.
- The eligible expense must be incurred by yourself, your Spouse, or one of your Dependents Expenses incurred by anyone else are not subject to reimbursement.
- The expense is not paid or reimbursed from any source other than through this Plan.
- The expense must be incurred during the Plan Year while your coverage is in effect.

Do I have to go to a specific provider?

No, you can visit any provider you would like and 100% of the service will be paid for until the annual maximum of $800 is reached.

Do leftover balances rollover from year to year?

No, unused benefits do not rollover.

How do I use the benefit?

Pay for your covered dental or vision service at the time of your visit by using your Visa Health Spending Card. You must use the card with your individual name on it and you must keep you receipts. You may be asked to verify your purchase by showing an itemized receipt with your name, provider name, date of service, and services rendered. Failure to supply this proof can result in your Dental and Vision account to be frozen. You MAY NOT use another family member's card to pay for your benefits.

What do I do if I lost my Visa Spending Card?

Contact the Fund Office so that your card can be cancelled, and a new one can be ordered. If you paid for services out of pocket, you may file a paper claim using the Dental/Vision HRA claim form which can be found on our website, or by calling the fund office.

DEATH BENEFIT

Who Provides this benefit?

The death benefits are provided by the International Union of Bricklayers and Allied Craftsmen Local 8 NY Welfare Plan

Who is eligible for this benefit?

The Death benefit is payable on covered Employees only. In other words, you must be enrolled in the health plan at the time of death to be eligible for this benefit. The Death benefit does not cover any Dependent. If you die from any cause while you are insured, the proceeds will be paid to your beneficiary. The Fund will continue to provide life insurance coverage for any Employee who retires while covered by the Plan, and continues to remain covered by the Plan.

Who can I name as my beneficiary?

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form which can be found on our website and mailing it to the Fund Office.

What if I don't have a beneficiary on file?

If you do not leave a named beneficiary, the benefit will be paid to your estate.

How much is this benefit for?

The current death benefit is $6,000.00.

How does my beneficiary claim this benefit?

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

PAID TIME OFF BENEFIT WAGE REPLACEMENT ACCOUNT

What is this account for?

To accommodate for New York State's Paid Sick Leave Law, BAC 3 NY and the various Employer Associations have negotiated into the 2022-2025 Collective Bargaining agreement a comparable benefit of $1/hour. The Wage Replacement Account will provide you with taxable paid time off or vacation benefits.

How is this account funded?

Employers are paying the $1.00/hour (reduced by a percentage rate for apprentices) as a pre-tax contribution to the BAC Local 3 Health & Welfare Fund.

How do I apply for payment for paid time off?

To claim Paid Time Off benefits, you must complete an application. A copy of the application can be obtained from the Fund Office or on Fund's website. The completed and signed application must be submitted to the Fund Office within 60 days after the end of the month in which your absence from work occurred. If your completed application is not received by the Fund Office within that 60-day period, you will not be entitled to the benefit and your claim will be denied.

How many days at a time can I request?

You may receive paid time off or vacation benefits from your Wage Replacement Account when not working for an Employer, provided you have a sufficient balance in your Wage Replacement Account. Paid Time Off must be used in increments of 4 hours (i.e., a half day) or 8 hours (i.e., a full day).

How do I know my account balance?

You can call or email the fund office during business hours to obtain the balance in your account.

How much will I be paid?

The amount of the benefit shall be equal to 8 hours of your base pay, specified in the BAC Local 3 NY Collective Bargaining Agreement, (or 4 hours of pay in the case of a half day), less applicable employee and employer Social Security, Medicare, unemployment taxes and income tax withholdings. If you apply for benefits for more than one day, you will receive one check for all days applied for assuming you have a sufficient balance in your WRA.

Can I request payment while I am collecting unemployment benefits?

No. You may not receive Paid Time Off benefits for time periods during which you are receiving unemployment benefits or after your retirement.

What happens to the unused balance at the end of the year?

Unused contributions will remain in your account for future use. However, the balance of your Wage Replacement Account will be forfeited 60 days after the end of the calendar year in which you retire.

How am I taxed on the payments made to me from this account?

Social Security, Medicare, unemployment taxes and income taxes will be withheld from your reimbursement. Your reimbursement will also be reduced by (as applicable) the employer Social Security, Medicare, and unemployment taxes. The Fund Office will issue a W-2 at the end of each year for reimbursements made. Please consult your tax advisor regarding the tax implications of using this benefit.

RETIREE PARTICIPANT ELIGIBILITY AND ENROLLMENT

How do I become eligible?

A retired member must have been *enrolled* in the Plan under normal active participant status for 10 consecutive years prior to retirement. This can not include any COBRA coverage.

Retiree Participants who work 1,200 hours or more in an Eligibility Period will be entitled to hospital, major medical, and prescription drug coverage through Excellus BCBS and Dental/Optical benefits, as provided to active participants for the next Benefit Year, without any out-of-pocket premium cost.

Retiree Participants who work less than 1,200 hours in an Eligibility Period are eligible for all the same hospital, major medical, and prescription drug benefits as offered to active participants for the next Eligibility Period, provided the Retiree Participant pays the *full* monthly premium charged by the Plan for coverage through Excellus BCBS. However, there will be no Dental/Optical benefits offered.

Who can be covered?

Retired members and their spouses or qualified domestic partners

Can I lose coverage as a retiree?

Yes. If a Retiree fails to make an installment payment, his/her coverage will be terminated. Once removed from the Plan, the retiree will no longer qualify for coverage under the Plan.

UNDER 65 RETIREE COVERAGE DETAILS

What does this Plan cover?

This Plan covers all of the same hospital, major medical, and prescription drug benefits, and medical HRA benefits as offered to active participants. However, no dental and vision benefit will be offered.

How much do I have to pay for this coverage?

Under 65 retiree coverage can be purchased at the full monthly premium charged by the carrier.

OVER 65 RETIREE COVERAGE DETAILS (MAPD Plan)

What is a Medicare Advantage PPO Plan?

Medicare Advantage Plans are an optional alternative to original Medicare. To qualify for Medicare Advantage Plans you must be enrolled in both Medicare parts A and B. Essentially, a Medicare Advantage PPO + Prescription Drug plan (MAPD) combines Medicare Part A, Part B, and Part D creating what is sometimes referred to as a Medicare Part C Plan.

Who can be covered?

You and your spouse (or qualified domestic partner), if applicable, become eligible for Medicare at age 65. To remain covered under this plan, you and your spouse must elect Medicare part A and B when you turn 65, at which time you should complete the application for the Medicare Advantage Plan enrollment. Contact the Fund Administrator for your enrollment packet prior to turning 65.

Eligibility for Medicare for Reasons other than Age:

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

What does this plan cover?

This Plan covers but is not limited to Doctors Visits, Hospital Services, Emergency Care, Rehabilitation, Supplies and Equipment, Prescription Drugs, and maximum annual out of pocket protection. At the time of enrollment, you will receive a benefit summary. Further details regarding the MAPD are available in the insurance contract or certificate of coverage. Refer to the certificate of coverage for a complete description of the plan's coverage, which you may obtain at no charge from the carrier or the Fund Office.

How much do I have to pay for this coverage?

The monthly premium rate will be equal to the monthly premium charged by the carrier and the amount automatically deducted by Medicare from your Social Security Check. Automatic monthly payments from your bank account can be set up with the Funds office. Payments by check should be made

payable to the BAC Local 8 NY Health Plan. Payment is due on the last business day of the month for the following month's coverage.

CONTINUATION OF BENEFITS (COBRA)

What is COBRA coverage?

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

What events qualify someone for COBRA coverage?

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

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

What is covered under COBRA?

Qualified beneficiaries will be offered coverage identical to the coverage provided under the Plan to similarly situated active employees and their family members (generally, qualified beneficiaries receive the same coverage they had immediately before qualifying for continuation coverage). Any change in benefits under the Plan that applies to active employees will also apply to qualified beneficiaries.

How long does COBRA coverage last?

In accordance with New York State insurance regulation, qualified beneficiaries can maintain their continuation coverage for up to a maximum of 36 months, regardless of the qualifying event. Continuation coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event. You will be granted a grace period of 30 days after the due date to make your payment. If you fail to make your payment before the end of the grace period, your coverage will be canceled, and you will lose your right to continuation coverage.

How much does COBRA coverage cost?

If you elect continuation coverage, you will be responsible for the full cost. A 2% administrative fee may be added. The premium will not exceed 102% of the cost to the plan for similarly situated employees covered under the plan who have not incurred a qualifying event.

COORDINATION OF BENEFITS

Can my dependents and I be covered under another plan in addition to this one?

Coordination of benefits (COB) refers to the provisions set forth in most group health plans that are applied when a person is covered by more than one group health insurance contract, plan, or policy. The first step in the coordination of benefits is to determine which group plan should be the "primary" plan. Generally, the primary plan is the one that pays benefits first; the secondary plan may pay some or all the difference between the amount paid by the primary plan and the total allowable expenses for the claim.

If you are overpaid for a claim for any reason, you must notify the Fund Office and refund the HRA administrator the amount of overpayment. Knowingly accepting unauthorized benefits is considered insurance fraud. Fraud is considered a federal crime, with imprisonment lasting up to 10 years. Fines can be significant varying from $10,000-$50,000 per charge of fraud healthcare practices. Overpayments often happen because of payment by another insurance plan such as that of a spouse.

CLAIMS AND APPEALS PROCEDURE

Insured Claims

Claims for health benefits that are insured, as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the insurance contracts with those insurers. You should refer to the insurance contract or certificate of coverage for full details regarding claims procedures, grievances, and appeals. If you have any questions regarding making or processing of claims and/or requests for review, you should review a current copy of the Insurance Benefit Booklet from the applicable insurance company. If you need an additional copy of the booklet, you may obtain one free of charge from the Fund Office.

HRA Claims

The Medical HRA only reimburses you for claims submitted first to the group insurance carrier.

Dental and Vison HRA claims may be submitted by using the debit card issued by the Plan or in writing using the claim form available on the Plan's website.

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

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

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

- the specific reason(s) for the denial or other adverse benefit determination.
- references to the specific Plan provisions on which the determination was based.
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary.
- a description of the Plan's review procedures and the applicable time limits.
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- if an internal rule, guideline, or protocol was relied upon in deciding your claim, either a copy of the rule or a statement that it is available upon request at no charge; and
- if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, you have the right to request a review of that determination. To do so, you (or your authorized

representative) must, within 180 days after you receive the notice of denial, submit your written request for review to the Board of Trustees. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records, or other information relating to your claim. The review will consider all comments, documents, records, and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

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

A different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including such additional documents and comments that may be submitted by you. If your claim was denied based on a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

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

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

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

Voluntary External Review

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

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

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

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

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

Paid Time-Off, Life Insurance Claims

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

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

For Paid Time-Off benefits, the completed and signed application must be submitted to the Fund Office within 60 days after the end of the month in which your absence from work occurred. If your completed application is not received by the Fund Office within that 60-day period, you will not be entitled to the benefit and your claim will be denied.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the Fund Administrator will notify you (or your duly authorized representative) within 90 days of receiving your claim. The 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Fund Administrator expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;

- what procedures you should follow to get your claim reviewed again by the Board of Trustees, and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 60 days after you receive the notice of denial, submit your written request for review to the Board of Trustees. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or, in the case of disability benefits, it constitutes a statement of Plan policy regarding the denied treatment or service.

A decision on review will be made by no later than the date of the meeting of the Board of Trustees of the Welfare Fund immediately following the Fund's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the Plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made. You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the specific reason(s) for the determination, with references to the specific plan provisions on which it is based. All decisions on review are final and binding on all parties.

FAMILY AND MEDICAL LEAVE AND NEW YORK PAID FAMILY LEAVE

If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "PFLL") you will be entitled to health and hospitalization insurance coverage under the Plan throughout the duration of your leave, but your Employer must contribute to the Plan a monthly premium equal to the required contribution

necessary for your coverage to continue. You will receive the type of coverage (i.e., family, or single) you were receiving prior to the leave, subject to any change you may have in family status.

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

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

MILITARY LEAVE

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If you receive a court issued Medical Child Support Order (MCSO) that requires you to provide your child or children with health coverage, the Fund Office must determine if the MCSO is “qualified” before providing the benefits called for by the order. You should contact the Fund Office if you are affected by

an MCSO. The Fund Office will determine if the MCSO is qualified within 10 to 90 days (depending on the difficulty of the determination). You will then be notified on how to proceed.

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

PROTECTION ACTS

Mental Health Parity Act

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

Women's Health and Cancer Rights Act

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

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

Normal plan deductibles and coinsurance apply.

Newborns and Mothers Health Protection Act

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

Health Insurance Portability and Accountability Act (HIPAA)

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

1. HIPAA Privacy and Security.

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

"Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the Plan provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A subcontractor of a Business Associate may be treated as a Business Associate. A Business Associate may be a Covered Entity. However, insurers and health maintenance organizations are not Business Associates of the plans they insure.

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

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

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

2. Uses and Disclosures of PHI.

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

3. Privacy Agreements with the Board of Trustees.

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

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

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

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

Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;

Report to the Plan's Privacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Plan of which the Board of Trustees becomes aware;

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

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

The Board of Trustees will make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

Make the Board of Trustees' internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

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

4. Employees with Access to PHI.

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

- Fund Administrator
- Administrative Assistant
- Plan Representatives

5. Mechanism for Resolving Noncompliance.

The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this summary. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the Participants whose privacy has been violated.

6. Security Agreements of the Board of Trustees.

As a condition of obtaining or maintaining e-PHI from the Plan, its Business Associates, insurers or HMOs, the Board of Trustees agrees it will:

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

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

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

Report to the appropriate party any security incident of which it becomes aware. For purposes of the Plan, security incident shall mean successful unauthorized access, use, disclosure, modification, or destruction of, or interference with, the e-PHI; and

Upon request from the Plan, the Board of Trustees agrees to provide information to the Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification, or destruction of the e-PHI to the extent such information is available to the Board of Trustees.

EMPLOYEE RIGHTS UNDER ERISA

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

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

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

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

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

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other plan members and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a penalty of up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Questions:

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

The nearest district office:

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

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

EBSA's Office of Member Assistance:
200 Constitution Avenue, NW,
Suite N-5623
Washington, DC 20210
Telephone: 202.693.8630
Fax: 202.219.8141

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

NOTES

BAC Local 3 NY Fund Office Beneficiary Form

☐ Buffalo Fund Office
1175 William St
Buffalo, NY 14206
(716) 842-1318
coneal@baclocal3ny.com

☐ Ithaca Fund Office
701 W. State St
Ithaca, NY 14850
(607) 272- 3853
atilebein@baclocal3ny.com

☐ Rochester Fund Office
33 Saginaw Dr
Rochester, NY 14623
(585) 385-1160
nhilger@baclocal3ny.com

complete all sections, sign and date

Participant Name: _____

SSN: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Marital Status: M S D W (Circle One) If divorced, proof must be provided.

Spouse Name: _____

Spouse SSN: _____ Spouse Date of Birth: _____

If you are married, your Pension and 50 % of your Annuity Beneficiary must be your spouse
Additional forms need to be completed to add your spouse as a dependent

Fund	**Welfare Beneficiary**	**Pension Beneficiary**	**Annuity Beneficiary**
Beneficiary Name:			
Beneficiary Address:			
Beneficiary DOB:			
Beneficiary SSN:			
Beneficiary Email:			
Relationship to You:			

Participant Signature: _____ Date: _____

If you are making changes to your beneficiary designation(s), this card will replace any previous designation(s).

*The Union and The International Pension Fund require a different form for their beneficiary designation. This form only updates your Ithaca Benefit Plan beneficiaries.

BRICKLAYERS LOCAL NO. 8 WELFARE FUND (the "Fund")

APPLICATION FOR PTO/VACATION BENEFITS

Return completed form and MOST RECENT PAYSTUB* to: Bricklayers Local No. 8 Welfare Fund, 701 West State Street, Ithaca, NY 14850. *Important Note on Timing: Your completed application must be received by the Fund Office within 60 days after the end of the month of the absence for which you are seeking benefits. If it is not received by that date, your claim will be denied as untimely.

PARTICIPANT INFORMATION

Name: _____

Social Security Number: _____

Address: _____

City:_____ State: _____ Phone No. _____

Trade: _____ Apprentice Level at time of leave: _____

Number of full and/or half days requested: _____

Date(s) absent from work (for each date, indicate whether a full or half sick day is being applied for):

_____

_____

_____

_____

PARTICIPANT CERTIFICATION

I certify that I did not work for a Contributing Employer on all or a portion of dates indicated above, nor did I receive wages for those dates. In addition, I am not receiving or entitled to receive unemployment benefits for a time period which includes any of such dates. Under penalties of perjury, I certify that the information contained in this form is true and correct to the best of my knowledge.

_____ _____

Date Signature

Penalty for Fraudulent or Incorrect Information

If the Fund pays PTO benefits that are in excess of what you are entitled to due to error (including for example, a clerical error), fraud, or for any other reason, the Fund reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action. See the SPD for further information

BAC Local 8 NY Health Plan Dependent Change Form

Employee Name: _____ Date of Birth: _____

Address: _____
Address City State Zip

SS#:_____ Phone#:_____ Email: _____

☐ I elect to add or remove the following dependents, as noted below, in the BAC Local 8 NY Group Health Plan. If adding, they will receive Medical and Rx coverage through Excellus BCBS and an $800 Dental/Optical benefit administered through LBS, effective the first day of the month following the receipt of this form by the Fund Office. I understand that I must return this form to complete enrollment and will notify the Fund Office of any changes as they occur. **If I am removing a dependent, I will submit proof of other insurance and the effective date with this form.**

Dependent Name	DOB	Dependent SS#	Relationship to Employee	Add	Remove
First Last	mm/dd/yyyy	123-45-6789	Spouse, Domestic Partner, (Step)Son, (Step)Daughter	X	

Please complete the section below if you are *adding* a dependent:

Are you or any dependents enrolled in a health or dental insurance Plan other than the BAC (including Medicare or Medicaid)? ☐ No ☐ Yes

If yes: are you keeping the additional coverage? Health ☐No ☐ Yes/ Dental ☐ No ☐ Yes / Vision? ☐No ☐Yes

Who did/does the other plan cover? ☐Self ☐Spouse ☐Children

Other Insurance Carrier(s) Name: _____Policyholder name: _____

Policy ID#_____ Effective Date: _____ Term Date:_____

*Please send copies of ID cards for other insurances including terminated plans.

X _____
Member Signature Date