DIVISION 1181 A.T.U. - NEW YORK WELFARE FUND
RETIREE SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Division 1181 A.T.U. – New York Welfare Fund is pleased to announce the following benefit improvements and additional claims and appeal rights to the Pre-65 Retiree benefit program. This document also includes changes to pre-65 Retiree benefit program, effective January 1, 2015, that were explained to you in the recent Summary of Benefits and Coverage. Finally, this document contains some clarifications to the Fund's Retiree Summary Plan Description ("SPD") that apply to both Pre- and Post-65 Retiree benefit programs. Please keep this document with your SPD.

Benefit Improvements, Copay Changes And Additional Claims and Appeal Rights, Effective January 1, 2015, For Pre-65 Retirees Only

1. The exclusion for "Experimental" treatment in Section 1 ("Definitions") on page 3 is changing:

> "Experimental" does not mean services under clinical trials to the extent required to be covered by law.

2. The following new subsection IV is added to Section 2 ("Eligibility for Benefits") on page 7 to limit the amount you have to pay for some benefits:

IV. ANNUAL OUT-OF-POCKET MAXIMUMS

> For pre-65 retirees only, there is a maximum annual limit on what you will have to pay out-of-pocket for certain in-network benefits (called "essential benefits"). Once you reach this out-of-pocket maximum, you will not be responsible for any deductibles, copays and coinsurance for these in-network essential benefits for the remainder of the year. For 2015, the out-of-pocket maximum for essential benefits is $3,600 for self-only coverage and $7,200 for family coverage. Any out-of-pocket expenses for non-essential benefits, any out-of-network costs and costs for excluded benefits do not count towards this out-of-pocket maximum.

3. The first two paragraphs of Subsection A(3) ("Maternity Care") under "Hospital Benefits for Pre-65 Retirees" on page 9 is replaced with the following:

> Maternity benefits are provided for expenses incurred in a Hospital by an Eligible Retiree or an Eligible Retiree's Spouse. Except to the extent required by law, maternity benefits are not payable for the pregnancy of a Dependent child.
>
> Hospital benefits will be provided for Hospital confinements arising from any pregnancy related condition, whether or not pregnancy is terminated. Additionally, Hospital benefits for routine nursery care of the newborn child or newly-born child adopted or placed for adoption with a Participant or a Dependent Spouse are provided during the mother's covered Hospital stay.

4. Subsection B(1) ("Emergency Treatment and/or Ambulatory Surgery") under "Hospital Benefits for Pre-65 Retirees" on page 10 is amended by adding the following to the end:

> Effective for services you receive on or after January 1, 2015, there is a $100 copayment for in-network emergency room services unless you are admitted to the Hospital. If you receive emergency room services in a Hospital that is not in Empire's network (a "non-Preferred Provider"), the Fund will pay the greater of (a) the Allowable Charge, or (b) the amount that would have been paid by Medicare for these services. As with all non-Preferred Providers, you are responsible for the difference between whatever the Fund pays and the Hospital's original charges.

5. Subsection A ("The Empire P.P.O.") under "Major Medical Benefits for Pre-65 Retirees" on page 14 is amended by adding the following:

> Effective for services received on or after January 1, 2015, when you use a Preferred Provider for services covered by the Plan, your copayment is $25.00 for each office visit with a primary care physician and $40.00 for a specialist. There is also a $25 copayment for in-network urgent care visits and in-network labs for diagnostic services.

6. Subsection E ("Well Child Care") under "Major Medical Benefits for Pre-65 Retirees" on page 17 is replaced with the following:

> For Dependents who are children, the Fund covers routine office visits to a Physician, immunizations and laboratory tests at the Fund's Allowable Charge at no cost sharing, if required by law.

7. The following new Subsection F is added on page 17:

F. PREVENTIVE CARE SERVICES

As required by law, the Fund covers a number of preventive services without any Plan cost-sharing for you and your Dependents, such as physical exams, screenings, tests, vaccines, and other preventive services on the following recommendation lists, to the extent required by law:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B;
- Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the CDC;
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

To the extent a recommended service is provided as part of a regular office visit with your provider, the copay for office visits still applies. However, you will not

be responsible for any copays or coinsurance for the above preventive services, if required by law.

For example, vaccines to treat HPV (such as Gardasil) are included in the recommended lists, so the 50% cost-sharing requirement on each Gardasil vaccine does not apply. The $25/$40 co-pay for an office visit will apply if the vaccine is part of a regular office visit. These recommended lists also include age, frequency, setting and other limitations that may affect your ability to receive coverage for the service. If you have any questions about whether a particular exam screening, test or vaccine is covered, please contact Empire at 1 (866) 513-2473.

Please note that if you use a non-Preferred Provider for these services, you still will be responsible to the Provider for the difference between the amount that the Fund would have paid a Preferred Provider and your provider's actual charge for the service.

8. Item 9 of Subsection F ("Limited Covered Medical Expenses") under "Major Medical Benefits for Pre-65 Retirees" on page 19 is deleted and replaced with the following:

9. Charges for two tobacco cessation attempts each year, which includes coverage for eight tobacco counseling sessions of 10 minutes in length each (including telephone counseling, group counseling and individual counseling) without prior authorization.

9. Item 6 of Subsection H ("Denial or Loss of Benefits") on page 19 is clarified by adding:

Non-prescription drug birth control or the insertion or removal of an IUD is covered, to the extent required by law.

10. Item 7 of Subsection H ("Denial or Loss of Benefits") on page 20 is replaced with the following:

7. Charges for injections, except as required by law and tetanus shots in connection with an Injury.

11. The following new subsection entitled "Additional Initial Claim Procedures" is added to the end of Section 13(II) ("Initial Claim Review") on page 43:

Additional Initial Claim Procedures (For Pre-65 Retiree Claims Only). Upon request, the Fund will provide you with the diagnosis codes, treatment codes and their corresponding meaning in connection with any adverse benefit determination made by the Fund. **However, making this request is not an appeal; see the appeal procedures that follow on how to appeal an adverse benefit determination.**

If you live in a county in which 10% or more of the population in that county is literate only in a non-English language (as determined by the federal government), you may request to receive any adverse benefit determination or

final adverse benefit determination in that non-English language. Please contact the Fund Office for more information.

12. Section 13(III) ("Appeal Procedures") on page 43 is amended by adding the following at the end:

If, on appeal, the Fund relies upon, considers or prepares new or additional evidence in connection with a claim, this evidence will be provided to you as required. Also, if the Fund denies your claim on a basis other than what is originally stated in your initial claim denial, the Fund will provide this basis to you.

13. Section 13 ("Claim Denials") on page 40 is amended by adding the following new subsection IV explaining your new rights:

IV. External Review of Denied Claims (For Pre-65 Retiree Claims Only)

1. Standard External Review. If you receive a final adverse benefit determination based on a medical judgment decision or a rescission of your coverage, you may appeal that determination to an external independent review organization ("IRO"). Claim denials for reasons other than medical judgment or rescission of coverage are not subject to external review.

A request for external review must be filed with the Fund Office within four months after you receive notice of the adverse benefit determination. The Fund will forward the claim IRO for review and the IRO will follow the procedure under the law for reviewing your claim.

Within five business days of receiving your external review request, the IRO will complete a preliminary review of your request to determine whether it is eligible for external review. Within one business day after the preliminary review is complete, the IRO will advise you of the decision. If your claim is eligible for external review, the IRO will review your claim.

In making its decision, the IRO will review all of the information and documents it timely receives and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its external review decision within 45 days after receiving the request for the external review. The IRO's decision notice will contain a general description of the claim and the reason for the external review request, including information sufficient to identify the claim (such as date(s) of service, the health care provider, the claim amount (if applicable)), the reason for the previous denial and other information required by law.

Upon request, the IRO will make available to you its records relating to your request for external review, unless a disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the Fund receives a final external review decision that reverses the Fund's adverse benefit decision, the Fund immediately will provide coverage or payment of the claim.

2. ***Expedited External Review.***

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay or emergency service, if the claimant has not yet been discharged from the facility. You also may request an expedited external review at the same time as an appeal to the Fund's Trustees, if the claimant requires urgent care or is receiving an on-going course of treatment.

Preliminary Review. Immediately upon receiving your request for expedited external review, the IRO will determine whether your request is eligible for standard external review as described above. The Fund immediately will send you a notice of its eligibility determination.

Referral to Independent Review Organization. Upon determining that a request is eligible for external review, the IRO will provide you and the Fund with notice of its decision as soon as possible but no later than 72 hours after it receives the review request.

14. Effective January 1, 2015, the "Notice of Grandfathered Status" on page ii no longer applies to the Pre-65 Retiree benefit program.

Technical Amendments and Clarifications For Both Pre- and Post-65 Retirees

15. Effective March 1, 2011, Section 2.I. ("Eligibility of Retirees"), paragraphs 1 and 2, are replaced with the following:

I. ELIGIBILITY OF RETIREES

You become eligible for benefits as an Eligible Retiree when you terminate your employment if:

1. you were employed at the time of your termination of employment by an Employer contributing to this Fund and/or any welfare funds that later merged into this Fund; and

2. you were eligible to receive a pension benefit from the Division 1181 A.T.U. – New York Employees Pension Fund or the Command – Local 1181 Pension Fund at the time of your termination of Employment based on 10 years of credited service earned under either pension fund.

This means that if you leave Employment with a vested right to a future pension but are not eligible to receive a pension benefit at the time, you are not entitled to Retiree Benefits. Also, if you are eligible for a pension benefit when you leave Employment, but you have less than 10 years of credited service, you also are not entitled to Retiree Benefits. For example, if you have earned 15 years of credited service, but stop working in Employment at age 53, you are not entitled to Retiree Benefits because you are not eligible to receive your pension benefit at the time you stop working under the Pension Fund. Also, if you have 7 years of credited service and you stop working in Employment at age 65, you are not entitled to Retiree Benefits because you have not earned 10 years of credited service, even though you are eligible to receive a pension benefit at the time you stop working.

16. Effective March 1, 2011, Subsection H under "Hospital Benefits for Pre-65 Retirees" on page 13 and Subsection E under "Hospital and Medical Benefits for Post-65 Retirees" are amended to clarify that animal organs and parts are covered, to the extent they are determined to be Medically Necessary.

17. Effective March 1, 2011, the first sentence of Subsection F ("Limited Covered Medical Expenses") under "Major Medical Benefits for Pre-65 Retirees," on page 17 is replaced with the following:

If both Spouses are Participants (i.e., you are a Participant under your coverage and a Dependent under your Spouse's coverage), your total benefits will not exceed the maximums in this Section.

18. Effective January 1, 2015, Item 2 of Subsection F ("Limited Covered Medical Expenses") under "Major Medical Benefits for Pre-65 Retirees" on page 17 is replaced with the following:

Charges in connection with routine dermatology treatment will be paid up to a $550 maximum per calendar year.

19. Effective January 1, 2014, the second paragraph of Section 9 ("COBRA Continuation Coverage") on page 34 is replaced with the following:

Upon termination of coverage, you also may have the option to buy an individual plan through the Health Insurance Marketplace ("Marketplace"). If you enroll in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally does not accept late enrollees. For more information about these options, including the Health Insurance Marketplace, visit www.HealthCare.gov.

20. Effective January 1, 2015, Section 10 ("Certificate of Creditable Coverage") on pages 37 and 38 is replaced with the following:

SECTION 10
CERTIFICATE OF CREDITABLE COVERAGE

In certain circumstances, federal law requires that the Fund provide you and your Dependent(s) with evidence of your coverage under the Fund for use as proof of prior coverage when beginning coverage under another health plan. After December 31, 2014, because of the elimination of preexisting condition exclusionary periods, you will no longer need the Fund to issue a Certificate of Creditable Coverage.

21. Effective January 1, 2014, the reference to "pre-existing conditions" in the subsection entitled "Termination of COBRA Coverage" on page 37 no longer applies and is deleted.

22. Effective January 1, 2014, the last sentence of Section 11 ("Qualified Medical Child Support Orders") on page 38 is deleted.

23. Effective March 1, 2011, Section 14 ("Subrogation and Reimbursement") is clarified by capitalizing "Dependent" throughout. Section 14 is also clarified by adding this sentence to the sixth paragraph starting on page 45:

> The Fund's constructive trust, lien and/or an equitable lien by agreement in favor of the Fund also applies to any amount received by you or your Dependent's estate that is due to the Fund under this Section.

24. Effective March 1, 2011, Section 15 ("Right of Recovery") is clarified by capitalizing "Dependent" throughout and adding this sentence to the second paragraph starting on page 47:

> The Fund's constructive trust, lien and/or an equitable lien by agreement in favor of the Fund also applies to any amount received by you or your Dependent's estate that is due to the Fund under this Section.

25. Effective December 9, 2014, the list of Employer Trustees in Section 17 ("Other Important Information") on page 54 is updated with the following Employer Trustee:

Corey Muirhead
Logan Bus Company Inc.
97-14 Atlantic Avenue
Ozone Park, N.Y. 11416