

**DIVISION 1181 A.T.U.
NEW YORK WELFARE FUND**



Retiree Summary Plan Description

**101-49 Woodhaven Blvd.
Ozone Park, NY 11416**

**Telephone:
(718) 845-5800**

DIVISION 1181 A.T.U. — NEW YORK WELFARE FUND

RETIREE SUMMARY PLAN DESCRIPTION

Revised as of March 1, 2011

DIVISION 1181 A.T.U. — NEW YORK WELFARE FUND

101-49 WOODHAVEN BOULEVARD
OZONE PARK, NEW YORK 11416
(718) 845-5800

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GENERAL INTRODUCTION

This document describes the benefits available to Eligible Retirees under the Division 1181 A.T.U. — New York Welfare Fund under the revised program of benefits, generally effective as of September 1, 2010 (“Plan”). This document is called the “Summary Plan Description” or “SPD.” The SPD also includes changes to the Plan to comply with the requirements of the Patient Protection and Affordable Care Act, generally effective January 1, 2011. The provisions of this document are subject to amendment and interpretation by the Board of Trustees and to the rules, regulations or procedures of the Plan in effect at the time of a claim. The Board of Trustees has the power to interpret, apply, construe, and amend the provisions of the Plan and make factual determinations regarding its construction, interpretation and application, and any decision made by the Board of Trustees in good faith is binding upon Eligible Retirees, Beneficiaries, and all other persons who may be involved or affected by the Plan.

This document is a description in English of the rights and benefits that pertain to you under the Division 1181 A.T.U. — New York Welfare Fund. If you have trouble understanding any part of this material, get in touch with the Fund Office (if you are a post-65 retiree) or a customer service representative at Empire Blue Cross Blue Shield (“Empire”) (if you are a pre-65 retiree). The address is Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Blvd., Ozone Park, NY, 11416. Telephone: (718) 845-5800. The Fund Office hours are 8:00 a.m. to 400 p.m. Empire’s address is Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. Telephone (866) 513-2473 (9:00 a.m. to 5:00 p.m. EST).

The benefits described reflect the benefits currently available, although the benefits provided may be revised from time to time. **It is absolutely necessary that you verify coverage with the Fund Office before incurring expenses under the Plan so that you can be sure that there is coverage for you or your Dependents.**

Benefits for Eligible Retirees may be modified or terminated by the Trustees at any time.

Notice — No Fund Liability. Use of the services of any hospital, clinic, doctor, or other provider rendering health care, whether designated by the Fund or otherwise, is the voluntary act of the Eligible Retiree or Dependent. Some benefits may only be obtained from providers designated by the Fund. This is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not employees of the Fund. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for the acts of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

Please remember that no one other than the Fund Office can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the Plan made by anyone else. It is extremely important that you keep the Fund Office informed of any change in address or desired changes in dependants and/or beneficiary. This is your obligation and you could lose benefits if you fail to do so. The importance of a current, correct address on file in the Fund Office cannot be overstated. It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

INFORMACION GENERAL

Este documento contiene un resumen y descripción de Fund (“Summary Plan Description”). Las provisiones de este documento están sujetas a enmendar y interpretar por el “Board of Trustees” (los fideicomisarios) y a las reglas, regulaciones y procedimientos del Plan en efecto al tiempo de reclamo. El “Board of Trustees” (los fideicomisarios) tienen el derecho de interpretar los términos de este documento y los interpretarán y aplicarán en situaciones no específicamente consiguadas en este documento. En caso de conflicto entre los términos de este resumen y los términos del Plan, los términos del Plan dominarán.

Este documento contiene, en Inglés, un resumen de beneficios y derechos en el Division 1181 A.T.U. — New York Welfare Fund que le pertenecen a usted. Si usted tiene dificultad entendiendo cualquier parte de este material, contacte a la oficina del Fondo y Empire. La dirección es Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Blvd., Ozone Park, NY, 11416 Teléfono: (718) 845-5800. Horas de oficina son de 8:00 A.M. hasta 4:00 P.M. La dirección de Empire es Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. Teléfono (866) 513-2473 (9:00 a.m. to 5:00 p.m. EST)

INTRODIKSYON JÉNÉRAL

Dokiman sa-a gen dé bagay ladan plan dokinan-an ak rézímé fund kidékri-l. Tout bagay ki andan-li kapab pasé men é intèprété pa Board of Trustees ask lwa yo, régilasyon oubyen prosedi plan ap pran aplikasyon nan tan yo egxijé-l. Board of Trustees gen dwa intèprété tout sa kinan dokiman, é kapab apliké-l nan yon sitiasyon ki pa nan dokiman sa-a.

Dokiman sila gen yon rézímé an anglè ki gen tout dwa akavantaj nan lokal Division 1181 A.T.U. New York Welfare Fund si-ou ta gen problèm pou konpran kinpot pati nan dokiman sa-a, kontaké Fund Office ou Empire, nan adres sa-a. Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Boulevard, Ozone Park, NY 11416. Tel: (718) 845-5800 lè office-la sé 8:00 a.m. a 4:00 p.m. es Empire, Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. Telephone (866)513-2473 (9:00 a.m. to 5:00 p.m. EST)

Notice of Grandfathered Status

The Division 1181 A.T.U. — New York Welfare Fund believes that both its Active and Retiree Plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, effective January 1, 2011, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund as set forth in this document. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform>.

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SECTION 1 DEFINITIONS

The following definitions are used throughout this booklet. The definitions will help you understand your benefits. Wherever the following terms are used, they have the following meanings:

Allowable Charge means the lowest of (1) the usual charge by the health care provider for the same or similar service or supply, (2) the charge that the Fund would pay under an agreement with a preferred provider organization to provide services to Covered Persons, or (3) the health care provider's actual charge (except for in-network hospital claims for pre-65 Retirees).

Active Benefits or **Active Plan** means the benefits received by Employees working in active Employment with an Employer.

Chiropractor means licensed professional acting within the scope of his or her license that performs manipulation of the spine and joints.

COBRA means the Consolidated Omnibus Reconciliation Act of 1985.

Covered Person means an Eligible Retiree and his or her Dependent(s).

Dependent means a person who meets the eligibility requirements of Section 2 of the SPD and who meets the below requirements:

A. In General. Dependent means the following: (1) your legal spouse (including a same-sex spouse) if such spouse is not legally separated from you, (2) your biological or adopted child, a child placed with you for adoption, your stepchild, or a child over whom you have guardianship rights from birth to the end of the month in which they become age 26, or (3) your foster child from birth to the end of the calendar year in which they become age 19. For a foster child, the child must be unmarried, be dependent upon you for support and maintenance and live with you in a regular parent-child relationship. These conditions do not apply to other dependent children. To enroll, official copies of birth certificates, adoption papers, or guardianship papers must be submitted to the Fund Office. Dependent also includes someone who is provided coverage under this Plan pursuant to a Qualified Medical Child Support Order ("QMCSO").

If a child age 19-26 is excluded from coverage due to being eligible for health coverage through the child's employer or the child's spouse's employment (see subsection B below), the child can still qualify as a Dependent provided that he or she satisfies the student coverage requirements set forth in subsection C or disabled child coverage under subsection D.

B. Exclusion for Children age 19-26 ("Adult Child"). If your Adult Child is eligible for health coverage through the child's employer or the child's spouse's employer, he or she will not be entitled to Dependent coverage under this Plan after the end of the calendar year in which the adult child attains age 19, unless he or she otherwise is entitled under the student coverage rules in subsection C below or disabled child coverage under subsection D.

To receive coverage, the Adult Child and the Participant will be required to complete a notarized form attesting that the child is not eligible for coverage through the child's employer or the child's spouses' employer. Failure to complete this form upon request from the Fund Office will result in your Adult Child being ineligible for Dependent coverage under this Plan.

- C. Student Coverage.** Your foster child (or any other child otherwise ineligible for coverage due to subsection B) who is a full-time student enrolled for at least 12 credits per semester (9 credits per trimester) in an accredited school may be a Dependent under the Plan until the end of the calendar year in which they become age 23. Letters from the school confirming full-time enrollment must be submitted to the Fund Office for each semester to maintain coverage of such children as Dependents. Contact the Fund Office for information regarding whether your child's school is an accredited school.

If a Dependent child, who is enrolled in student coverage under this paragraph, is on a medically necessary leave of absence from an accredited school because of a serious injury or illness, coverage under this Plan will be extended, free of charge, during the leave of absence until the earlier of (i) the one-year anniversary of the date on which the leave of absence began, or (ii) the date on which the Dependent child's coverage under the Plan would otherwise terminate. To be eligible for this extended coverage, the Participant must provide the Plan with written certification from the Dependent child's treating physician that the leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage commences on the date such certification is received by the Fund, but will be retroactive to the date on which the leave of absence began. Extended coverage under this paragraph will run concurrently with coverage under COBRA. This means that if the Dependent child receives one-year of extended coverage under this paragraph and, after the expiration of this one-year period, the Dependent child is not otherwise eligible for Plan coverage in accordance with the above paragraphs, the child can only elect to continue coverage under COBRA for up to an additional 24 months, not 36 months.

- D. Dependents with Disabilities.** Any Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability, may be a Dependent under the Plan, provided such child suffered the incapacity prior to reaching age 19 and is dependent upon you for support and maintenance. In such circumstances, you must submit a comprehensive medical report including date of onset and expected duration of the disability to the Fund Office. From time to time, additional medical certification of continued disability may be required by the Fund to maintain coverage of such children as Dependents. Any dependent qualifying for coverage under this paragraph will not be subject to the employment exclusion set forth in subsection B above.

- E. Multiple Coverage under the Plan.** In the event that both parents are Eligible Retirees, then such child will be considered a Dependent of both.

- F. Coordination Between Pre-65 and Post-65 Retiree Coverage for Dependents.** Even if an Eligible Retiree attains 65 or becomes Medicare-eligible, his or her spouse remains entitled to pre-65 Retiree coverage until he or she attains age 65 or becomes Medicare-eligible. Likewise, an Eligible Retiree's dependent children continue to be covered under Pre-65 Retiree coverage until the later of (1) the Eligible Retiree or the Eligible Retiree's spouse attaining age 65 or becoming Medicare-eligible, or (2) until the Dependent child no longer meets the definition of Dependent under this Plan.

Disability means an inability to perform the substantial and material duties of the disabled person's occupation or employment due to Injury or Sickness.

Eligible Retiree means a Retiree who meets the eligibility requirements of Section 2 of the SPD.

Employee means (A) employees covered by collective bargaining agreements between an Employer and the Union; (B) eligible employees of the Union; and (C) employees of the Division 1181 A.T.U. — New York Welfare Fund, the Division 1181 A.T.U. — New York Employees Pension Fund and/or (D) employees of the Division 1181 Credit Union.

Employer means an employer that agrees to be bound by the terms of the Division 1181 A.T.U. — New York Welfare Fund and the Trust Agreement and to participate in and contribute to the Division 1181 A.T.U. — New York Welfare Fund on behalf of its Employees whether by agreement with the Union or by agreement with the Trustees. The Union, Division 1181 A.T.U.- New York Employees Pension Fund, Division 1181 A.T.U.- New York Welfare Fund and Division 1181 Credit Union are Employers only to the extent that they make contributions to the Fund for Fund coverage of their Employees and shall not be considered Employers for any other purpose.

Employment means a position with an Employer for which contributions are required to be made to the Fund.

ERISA means the Employee Retirement Income Security Act of 1974, amended from time to time.

Experimental or Investigative A drug, device, medical treatment, or procedure is considered experimental or investigative unless:

- A. The approval of the U.S. Food and Drug Administration and approval for marketing the drug or device for the particular purpose being requested has been given at the time the drug or device is furnished;
- B. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;
- C. Reliable evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- D. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Fund means the Division 1181 A.T.U. — New York Welfare Fund established under the Trust Agreement.

Home Health Care Agency means an agency or organization that meets each of the following requirements: (A) it is primarily engaged in and is Federally certified as a Home Health Care Agency and duly licensed (if such licensing is required) by the appropriate licensing authority to provide nursing and other therapeutic services; (B) its policies are established by a professional group (including at least one Physician and one registered nurse) associated with such agency or organization to govern the services rendered; (C) it provides for full-time supervision of such services by a Physician; (D) it maintains a complete medical record for each patient; and (E) it has an administrator.

Home Health Care Plan means a program for care and treatment of a Covered Person established and approved in writing by the Covered Person's attending Physician prior to the start of Home Health Care services. The Physician must also state in writing that hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act of 1965, as amended, would be required if home care is not provided.

Hospital means an establishment that meets all of the following requirements: (A) holds a license as a general hospital (if licensing is required in the state); (B) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (C) provides 24-hour a day nursing service by registered or graduate nurses on duty or call; (D) has a staff of one or more licensed Physicians available at all times; (E) provides organized facilities for diagnosis and surgery either on its own premises or at an institution with which it has a formal arrangement for the provision of such facilities; (F) is not primarily a clinic, nursing, rest or convalescent home or an extended care facility or a similar establishment and (G) is not (other than incidentally) a place for treatment of alcoholism or drug addiction. Confinement in a special unit of a hospital used primarily as a nursing, rest, convalescent home or extended care facility is deemed, with respect to the coverage provided by the Plan, to be confinement in an institution other than a hospital.

Immediate Family means the spouse, brothers, sisters, parents, children, aunts, uncles, nephews and nieces of an individual.

Injury means bodily injury caused directly by an accident resulting in a loss covered by the Plan.

Medically Necessary means a medical treatment that is required to identify or treat the Sickness or Injury that a Physician or Dentist or other provider of health care has diagnosed or reasonably suspects. The service must be: (A) consistent with currently accepted medical practice and with the diagnosis and treatment of the condition; (B) in accordance with local standards of good medical practice; (C) required for reasons other than the person's or the health care provider's convenience; (D) performed in the least costly setting required by your condition; and (E) not Experimental in nature.

Medicare means benefits under Title XVIII of the Social Security Act of 1965, as amended.

Physician means a licensed doctor of medicine acting within the scope of his or her license. It also means a chiropractor and doctor of osteopath sciences.

Plan means the plan of benefits under the Division 1181 A.T.U. — New York Welfare Fund.

Podiatrist means a licensed professional acting within the scope of his or her license who performs treatment of the feet.

Retiree Benefits mean the benefits available to Eligible Retirees from the Fund, as described in the Plan.

Room and Board means all charges commonly made by a Hospital on its own behalf for a room and meals and for general services and activities essential to the care of bed patients.

Sickness means a non-occupational illness, condition or disease that requires treatment by a Physician and that causes a loss covered by the Plan. Losses incurred because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any other Sickness.

Successive Periods of Confinement means two or more periods of Hospital confinement or Surgical Procedures due to the same or related causes and are considered one confinement or procedure unless they are separated by 90 days.

Sudden Serious Sickness or Injury means a Sickness or Injury diagnosed by a Hospital as life-threatening, health-threatening or seriously impairing bodily functions so that care and treatment in an acute care Hospital facility was the only medical course indicated.

Trust Agreement means the Agreement and Declaration of Trust of the Fund as amended from time to time.

Trustees means the Board of Trustees of the Fund.

Union means Division 1181-1061, Amalgamated Transit Union, AFL-CIO.

You or **Your** refers to the Retiree, unless the context clearly indicates otherwise.

SECTION 2 ELIGIBILITY FOR BENEFITS

Eligible Retirees and Dependents are eligible for benefits under the Plan under the following rules:

I. ELIGIBILITY OF RETIREES

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

1. you were employed at the time of your termination of employment by any Employer who contributed to this Fund and/or any of the welfare funds that were 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.

This means that if you leave Employment with a vested right to a future pension benefit but are not eligible to receive a pension benefit at that time, you are not entitled to Retiree Benefits.

You must actually submit your papers to retire within (60) days of terminating employment. If you delay in the filing of your retirement, you may sacrifice your right to receive your Retiree Benefits and may have to appeal to the Board of Trustees to request reconsideration.

When you retire and begin receiving your pension benefit, you may elect to receive either COBRA Continuation Coverage or Retiree Benefits. If you elect to receive COBRA Continuation Coverage, you will be eligible to receive Retiree Benefits when your COBRA Continuation Coverage terminates. **However, if you elect COBRA Continuation Coverage at the time you leave Employment with an Employer and do not begin to receive a pension benefit immediately, you will not be eligible for Retiree Benefits when you do retire.**

If you or your Dependent become eligible for Medicare coverage, you must enroll in both Part A and the elective Part B. IF YOU FAIL TO ENROLL IN MEDICARE PART A or B, BENEFITS WILL ONLY BE PAID AS IF YOU WERE ENROLLED IN MEDICARE AND MEDICARE MADE A PAYMENT UNDER PART A OR B.

PLEASE NOTE: IF YOUR SPOUSE IS AN EMPLOYEE IN ACTIVE EMPLOYMENT AND IS ELIGIBLE FOR BENEFITS FROM THE FUND AS A PARTICIPANT, YOU WILL CONTINUE TO BE COVERED AS A DEPENDENT FOR THE ACTIVE BENEFITS PROVIDED FOR ALL DEPENDENTS OF PARTICIPANTS.

If you opt-out of Active Plan coverage, you can still be eligible for Retiree Benefits upon retiring after you terminate employment, provided that you meet the requirements and follow the procedures set forth above. However, because you were not enrolled in Active Plan coverage at the time of termination, you will not be entitled to receive COBRA continuation coverage upon terminating employment.

II. ELIGIBILITY OF DEPENDENTS

Dependents become eligible for benefits under the Plan on the same day as you do. To be eligible for benefits, **you must add the Dependent to your enrollment card. For example, when you have a child or get married, you must add the new child or spouse to your enrollment card.**

You must submit documentation of any legal separation or divorce within 10 days of the effective date of the separation or divorce. It is your responsibility to reimburse the Fund any monies paid by the Fund on anyone's behalf in error as a result of your failure to notify the Fund of your legal separation or divorce. For stepchildren, please contact the Fund Office for the documentation you must complete for your stepchild to be eligible for coverage.

You may add or remove a Dependent from enrollment at any time. To add or remove a Dependent, you must request the change in writing, stating when you want the removal to be effective and submitting a new enrollment card. You must also provide the Social Security Number of the Dependent to be added or removed and documentation to support the change such as proof of marriage, birth, adoption, guardianship, or foster care placement, to add a spouse or child as a Dependent, proof of disability to extend a child's coverage, or proof of divorce, death or end of dependency to remove a Dependent.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement of adoption. If you apply for dependent coverage for a new child within 30 days, biological children and/or newborn children adopted or placed for adoption with a participant may be added as of the date of birth or adoption.

III. MONTHLY CO-PAYMENT

In order for you and your Dependents to be eligible for Retiree Benefits, you must pay a monthly co-payment of \$25.00. If you do not pay this co-payment, your Retiree Benefits will terminate. Once terminated, you will not be able to elect to receive Retiree Benefits at a later date. However, even if you fail to pay the \$25.00 co-payment, you will still be eligible for Life Insurance Benefits as long as you meet the above eligibility requirements for Retiree coverage.

Your co-payment must be paid through a deduction from your monthly pension benefit. The Fund Office will provide you with a form for this purpose.

SECTION 3 TERMINATION OF COVERAGE

Your coverage for Retiree Benefits will continue until your death, or the first day of the month in which you fail to pay the monthly co-payment, as described in Section 2(III), except to the extent otherwise provided. However, benefits for Retirees may be modified or terminated by the Trustees at any time.

Coverage for Dependents terminates on the earlier of (1) your death or (2) the date the individual no longer meets the definition of Dependent (for example, the date you and your spouse are legally separated.) See Section 9 for information regarding your Dependent's right to COBRA Continuation Coverage.

SECTION 4 BENEFITS PROVIDED

The following benefits apply to Eligible Retirees and Dependents who are entitled to Retiree Benefits as stated below. The benefits provided under this Retiree Plan are different for pre-65 Retirees and post-65 Retirees, except where noted.

I. LIFE INSURANCE

This benefit applies to both pre- and post-65 Retirees. The Fund has a contract with Standard Life Insurance Company, 360 Hamilton Avenue, Suite 210, White Plains, NY 10601-1871 for life insurance benefits. These benefits are paid through the insurance contract and the insurance company provides claim processing services for these benefits. For deaths occurring on or after May 1, 2008, the Fund provides \$9,000 in life insurance for Eligible Retirees through Standard Life Insurance Company.

An original death certificate must be submitted to the Fund Office. The benefit will be payable to the individual(s) designated as beneficiary(ies). Please contact the Fund Office before designating a minor as your beneficiary.

You may designate your beneficiary, and may change the designation, in writing in the form and manner required by the Trustees. The designation or change will become effective only when it is entered on the Fund's records, as long as the Fund has not made payment or taken other action before the entry was made. The consent of the beneficiary is not required for any change of beneficiary. If no beneficiary has been designated or if your beneficiary is not alive when you die, then the Fund may pay the death benefit in accordance with the rules in this Section.

A beneficiary also may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation will become effective only when it is entered on the Fund's records, as long as the Fund has not made payment or taken other action before the entry on its records was made. A beneficiary designation in a court order meeting the above requirements will supercede any prior or subsequent

conflicting beneficiary designation that is filed with the Fund Office.

A beneficiary may waive his or her rights as a beneficiary under the Plan in an entered court order, provided that such order contains a clear waiver of rights. The waiver will become effective only when it is entered on the Fund's records, as long as the Fund has not made payment or taken other action before the entry on its records was made. A waiver in a court order meeting the above requirements will supercede any prior conflicting beneficiary designation that has been filed with the Fund Office. If a court order meeting the above requirements contains a waiver of rights by the beneficiary on file with the Fund Office, and you subsequently die without naming a new beneficiary, then the Fund may pay the death benefit in accordance with the rules in this Section.

The Trustees shall be the sole judges of the effectiveness of the designation, change or waiver of a beneficiary pursuant to this Section.

II. HOSPITAL/MAJOR MEDICAL BENEFITS FOR PRE-65 RETIREES

The Hospital and Medical Benefits provided to pre-65 Eligible Retirees and their Dependents who are not entitled to Medicare are the same as the Hospital Benefits provided to Eligible Employees and are described in detail below. Once an Eligible Retiree becomes eligible for Medicare, this Plan pays as secondary. Please refer to subsection III of this Section for details on Hospital and Major Medical Benefits provided to post-65 Retirees.

HOSPITAL BENEFITS FOR PRE-65 RETIREES

The Fund provides the following Hospital Benefits to each Covered Person. There is a \$500,000 annual maximum Hospital benefit payable on behalf of each Covered Person:

The Fund has arranged with Empire, for you and your dependents, a network of preferred Hospitals from which to choose. Because participating Empire Hospitals have agreed to accept lower charges for Hospital services than non-Empire Hospitals, you and the Fund save money.

REMEMBER, THE PLAN COVERS THE SAME SERVICES WHETHER YOU USE AN EMPIRE HOSPITAL OR NOT, SO SERVICES THAT ARE NOT COVERED BY THE PLAN WILL NOT BE COVERED JUST BECAUSE YOU USED AN EMPIRE HOSPITAL.

A. IN-PATIENT SERVICES

PRECERTIFICATION IS REQUIRED ON ALL ELECTIVE ADMISSIONS, ALL IN-PATIENT ADMISSIONS AND ANY SURGICAL PROCEDURES PERFORMED IN ANY FACILITY.

1. Room and Board. The Fund will cover up to one hundred twenty (120) days of Room and Board.

The Fund will cover 120 days of Room and Board during a single hospitalization or during several separate hospitalizations, as long as there are fewer than 90 days between admissions. If there is more than 90 days between admissions, a new 120-day period will begin with the next hospitalization. After you have used the 120 days of Room and Board, there must be at least a ninety (90) day period of separation between hospitalizations before another period of hospitalization will be covered.

In the event you or your Eligible Dependent are totally Disabled when your Employment terminates, Hospital Benefits continue for the Disabled Covered Person for the period of the Hospital confinement, or for surgery related to that Disability, provided care is being rendered at the time of or within 31 days after the date Employment terminates.

This extension of Hospital Benefits will end when the Covered Person is no longer Disabled, when the maximum Hospital Benefits have been provided, or when the Covered Person becomes eligible for benefits from, or insured under, another group health plan or policy, available under another group program, whichever comes first.

Semi-private Accommodations: If you or your Eligible Dependent is a Hospital patient in a semi-private room, Room and Board and general nursing care are covered for up to 120 days.

Private Accommodations: If you or your Eligible Dependent is a Hospital patient in a private room, the Plan provides for a daily allowance equal to the Hospital's average semi-private room charge for Room and Board and general nursing care.

2. Other Hospital Services. You and your Eligible Dependents are covered for the following services:

- a. Use of operating and cystoscopic rooms and equipment;
- b. Use of recovery room and equipment;
- c. Laboratory examinations;
- d. X-ray examinations;
- e. All drugs and medicines for use in the Hospital, including radium or radioactive substances, which are commercially available for purchase and readily obtainable by the Hospital;
- f. Blood, blood storage, use of blood transfusion equipment and administration of blood or blood derivatives when given by a Hospital employee;
- g. Oxygen and use of equipment for its administration;
- h. Anesthesia supplies and use of anesthesia equipment;
- i. Dressings and plaster casts;
- j. Use of cardiographic equipment;
- k. Physiotherapeutic and hydrotherapeutic treatments when administered by a Hospital employee;
- l. Hospital confinement or any period of Hospital confinement primarily for rehabilitation for up to 20 days per calendar year. Rehabilitation Services are covered only when provided in accredited units, as an extension of a hospitalization for an accident or Disability, and when a patient with a Disability has a clear potential for functional improvement;
- m. Charges for radiation therapy and/or chemotherapy; and
- n. Out-patient diagnostic testing.

3. Maternity Care

Maternity benefits are provided for expenses incurred in a Hospital by an Eligible Retiree's or an Eligible Retiree's Spouse. Maternity benefits are not provided 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 Covered Person are provided during the mother's covered Hospital stay.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

4. Newborn Children

Benefits are available from birth or from the adoption or placement for adoption of a newborn infant for:

- a. The treatment of Sickness or Injury;
- b. Neo-natal in-patient care, including nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds); and
- c. Incubator care, regardless of the infant's weight.

5. Co-payment for Non-Empire Facility

There is a \$500 co-payment for all elective admissions and ambulatory procedures performed in a non-Empire facility, unless it is the only facility performing the procedure. In the event that both parents of a Dependent child are Eligible Retirees and the Dependent child has such procedures performed at a non-Empire facility, there will be only one co-payment.

B. OUT-PATIENT SERVICES

Hospital benefits are provided in the event you or your Eligible Dependent is not admitted as a bed patient but receives care in a Hospital emergency room or operating room for:

1. Emergency Treatment and/or Ambulatory Surgery

- a. Emergency first aid during the first visit for treatment of an accidental Injury within 72 hours following such Injury;
- b. Emergency care during the first visit for treatment within twelve (12) hours of the onset of Sudden Serious Sickness or Injury;
- c. Ambulatory minor surgery, defined as surgery for which the patient is discharged on the same day as the surgical procedure.

2. Presurgical Testing

- a. Hospital benefits are provided for diagnostic tests when they are prescribed by your Physician as a preliminary to scheduled surgery, are given within fifteen (15) days prior to scheduled surgery, and are performed in the same Hospital in which the surgery is performed.
- b. Hospital benefits for out-patient services, will be provided for up to a total of thirty (30) visits per calendar year, except for dialysis. Ambulatory surgery will be covered under the same benefits and limitations as in-patient surgery.

3. **Out-Patient Chemotherapy.** Hospital benefits are provided for out-patient chemotherapy administered by a Hospital employee, including medications.
4. **Mammography Screening.** Hospital benefits are provided for mammography screening upon a Physician's request.
5. **Colonoscopies.** Facility and physician fees for colonoscopies are covered only to the extent of the Allowable Charge for the procedure if it is performed in a doctor's office or in a Hospital.

C. HOME HEALTH CARE

Hospital benefits for Home Health Care are available only for services rendered:

1. under a Physician approved Home Health Care Plan;
2. by a Home Health Care Agency;
3. with prior approval by the Fund; and
4. if hospitalization or confinement to a skilled nursing facility would otherwise have been required.

Benefits for Covered Home Health Care services are as follows:

1. If Covered Home Health Care services are rendered by a Home Health Care Agency and begins within 7 days of discharge from a Hospital, full coverage will be provided for a maximum of 200 home care visits per calendar year.
2. If Covered Home Health Care services are rendered without prior confinement to a Hospital or through an agency that is not a Home Health Care Agency under the Plan's definition, there will be a \$50 cash deductible, and the Fund will pay 75% of the Agency's charge, up to the Allowable Charge, for a maximum of forty (40) home care visits per calendar year.
3. Covered Home Health Care services include: part-time professional nursing; part-time home health aide services (4 hours of such care is equal to one home care visit); physical, occupational or speech therapy; medical supplies, drugs and medicines prescribed by a Physician; and laboratory services.

When home care is provided through a Home Health Care Agency, and begins within 7 days following discharge from a Hospital, Covered Home Health Care services also include: medical social worker visits; X-ray and EKG services; and ambulance or ambulette to the Hospital for needed care.

D. SKILLED NURSING FACILITY

The Fund will allow up to 30 days per calendar year for care at a skilled nursing facility, if facility admission is determined to be Medically Necessary through the Empire pre-authorization and discharge planning process. This 30-day limited benefit is allowed for Participants who may safely be discharged from a Hospital but not safely discharged to home or home with home care assistance because there is a need for on-going medical care that can be provided at a level that is less than an acute Hospital in-patient level of care. This placement requires pre-certification through Empire and is only available in connection/conjunction with a Hospital stay.

E. SPECIAL CONDITIONS

1. Mental or Nervous Disorders

Hospital benefits for mental or nervous disorders are available up to 120 days during a single hospitalization or during several separate hospitalizations, as long as there are fewer than 90 days between admissions, in any Hospital in which Hospital benefits are provided, and in any separate, psychiatric division of any general Hospital. If there is more than 90 days between admissions, a new 120 day period will begin with the next hospitalization. After you have used the 120 days, there must be at least a ninety (90) day period of separation between hospitalizations before another period of hospitalization will be covered.

2. Dialysis for Kidney Failure

Hospital benefits are provided for hemodialysis or peritoneal dialysis while you or your Dependent are a registered bed patient in a Hospital.

Hospital benefits are also provided for out-patient dialysis, as follows:

- a. For dialysis at home, the Fund will pay the cost of all appropriate and necessary supplies as well as the Allowable Charge for rental cost of the required equipment and the attending nurse.
- b. For dialysis at a Hospital or freestanding facility, the Fund will pay the cost of treatment of the Hospital's or facility's dialysis program.

F. HOSPICE CARE

You and your Eligible Dependents have coverage for up to 210 days of in-patient hospice care in a hospice or Hospital, and home care and out-patient services provided by the hospice as described below if:

1. The hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law; or if the hospice is located outside of New York State, under a similar certification process required by the state in which the hospice organization is located and the Covered Person has been accepted by the hospice program for such care; and
2. The Covered Person has been certified by such covered hospice as having a life expectancy of six (6) months or less.

Covered hospice services include:

1. Bed patient care either in a designated hospice unit or in a regular Hospital bed, and day care services provided by the hospice organization.
2. Home care and out-patient services provided by the hospice and charged to the Covered Person including:
 - a. Intermittent care by a registered nurse (R.N.), licensed practical nurse (L.P.N.) or Home Health Aide;
 - b. Physical therapy;
 - c. Speech therapy;
 - d. Occupational therapy;
 - e. Respiratory therapy;
 - f. Social services;
 - g. Nutritional services;

- h. Laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms;
- i. Medical supplies;
- j. Drugs and medications prescribed by a Physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary; (not covered when the drug or medication is of an experimental nature);
- k. Medical care provided by the hospice Physician;
- l. Five visits for bereavement counseling for the Covered Person's family either before or after the Covered Person's death;
- m. Durable medical equipment provided prior Fund approval is obtained;
- n. Transportation between home and Hospital or hospice organization provided such transportation is Medically Necessary.

G. WORLDWIDE PROTECTION

Hospital benefits cover services rendered anywhere in the world. Elective treatment outside of the United States requires prior Fund approval.

H. ORGAN TRANSPLANTS

Where the organ transplant procedures are determined by the Plan to be experimental in nature or obsolete, benefits are not payable under the Plan. For Hospital benefits to cover organ transplants, prior written approval must be obtained from the Fund, and the transplant must take place at a facility approved by the Fund for that procedure.

If the recipient of the organ is a Covered Person, Hospital Benefits for approved organ transplants include costs related to the donation of an organ used in the transplant procedure, such as Hospital charges to obtain, store and transport the organ, as long as no other coverage is available from other sources.

The Covered Expenses of the organ donor, if the donor is a Covered Person under the Plan, will be paid in accordance with the Allowable Charge, even if such expenses would not be covered because such surgery could be determined to be not Medically Necessary for the donor. The Covered Expenses of the organ donor, if the donor is not a Covered Person under the Plan, will be paid in accordance with the Allowable Charge only if health coverage is unavailable from all other sources.

Transplants of animal organs or parts are excluded from coverage.

Where other funding (such as government or institutional sources) is available for an organ transplant, the Fund is the secondary payor and all other sources of funding must be exhausted before the Fund is obligated to pay benefits.

I. LARGE CLAIM SETTLEMENT PROGRAM

Effective January 1, 2005, the Board implemented a large claim settlement program. In the sole discretion of the Board of Trustees, based on the Fund's financial circumstances, the Board may designate an amount to be used to attempt, through negotiated settlements, to resolve claims in excess of the annual or lifetime maximum Hospital or Major Medical benefit payable on behalf of each Covered Person. Please contact the Fund Office for more details on this program if you have all or part of a claim that is not covered because it exceeds the maximum Hospital or Major Medical benefit.

J. DENIAL OR LOSS OF BENEFITS

In addition to the exclusions applicable to all forms of benefits under the Plan, Hospital benefits are not provided for:

1. Confinement for sanitarium-type, nursing home, skilled nursing facility, custodial or convalescent care, or for rest cures;
2. Non-institutional services such as private duty nursing and services by practitioners (such services may be covered by Major Medical Benefits);
3. Charges by a professional person who is not a salaried member of the Hospital staff, who provides services in the emergency room (such charges may be covered by Major Medical Benefits);

K. HOW TO CLAIM HOSPITAL BENEFITS

You should present your Empire Direct Plus ID Card to the Hospital admitting clerk. Hospital bills will be sent from the Hospital to Empire and will be paid directly to the Hospital. Pre-certification is required for in-patient and ambulatory services.

Covered Persons should not make any payments to a Hospital, with the exception of personal items, T.V. rental or, for a private room, the difference between the Hospital's average semi-private room charge and the private room charge.

A copy of any correspondence you receive from a Hospital should be sent to Empire or the Fund Office immediately.

MAJOR MEDICAL BENEFITS FOR PRE-65 RETIREES

Major Medical benefits are provided in two ways by the Fund.

-- The Fund has made available to you and your Dependents a preferred provider organization ("PPO") with Empire BlueCross/Blue Shield. With the Empire P.P.O. you are allowed to choose from among the Physicians or other medical specialists in the Empire network. These medical providers are called Preferred Providers. If you use an Empire provider, generally you only pay the Co-Payment, if any, to receive treatment for services covered by the Plan, except as otherwise provided in this Plan. Pre-certification is not required for office visits.

-- If you do not use an Empire Preferred Provider for your Major Medical benefit, the Fund only will pay Allowable Charge, which is the lesser of the amount that the Fund would have paid an Empire Preferred Provider for the procedure or the provider's actual charge for the procedure and you will be responsible for the unpaid balance. Since Empire negotiates lower fees with the providers in its P.P.O., you likely will have to pay much more of the bill if you use a provider that is not part of the Empire P.P.O.

REMEMBER, THE PLAN COVERS THE SAME SERVICES WHETHER YOU USE AN EMPIRE PREFERRED PROVIDER OR NOT, SO SERVICES THAT ARE NOT COVERED BY THE PLAN WILL NOT BE COVERED JUST BECAUSE YOU USED AN EMPIRE PREFERRED PROVIDER. HOWEVER, USING AN EMPIRE PREFERRED PROVIDER FOR COVERED SERVICES SAVES YOU AND THE FUND MONEY.

A. THE EMPIRE P.P.O.

The Fund's contract with Empire makes Empire's network of Physicians and laboratories available to you and your Dependents. This is called a Preferred Provider Organization ("P.P.O."). Using Physicians that are part of the P.P.O. saves you and the

Fund money. With the P.P.O., you are allowed to choose from among the Physicians or other medical specialists in the Empire network. These medical providers are called Preferred Providers. It is not necessary to have a referral from a primary care Physician. When you use a Preferred Provider for services covered by the Plan, your co-payment is \$15.00 for each office visit. However, if Limited Covered Medical Expenses are used, you are responsible for paying the provider the difference between the Fund's payment and the Physician's charges. **You are always responsible for paying the Preferred Provider for any non-covered services.**

To use a Preferred Provider, simply follow these steps:

1. Check your Empire P.P.O. Provider Directory for the nearest Preferred Provider. The directory lists Physicians according to location and type of practice.
2. Select a Physician from the directory and schedule an appointment. Verify that he or she is participating in the Empire P.P.O. Network.
3. For visits in either the home or office, show your Empire ID Card and pay the \$15 co-payment.
4. The Fund's contract with Empire covers diagnostic services, as listed on page 16. Show your Empire ID Card. There is no co-payment. Using an Empire facility can save you money because the Empire facilities will accept payment by the Fund as full payment. Your Empire directory lists the locations where you can have tests done.

If you would like additional information, call an Empire Customer Service Representative at 1-866-513-2473 (9:00am – 5:00pm EST).

B. ANNUAL MAXIMUM MAJOR MEDICAL BENEFIT

The Annual Maximum Major Medical benefit payable on behalf of each Covered Person is \$1,000,000.

C. SURGICAL PROCEDURES

If you or your Eligible Dependents undergoes a surgical procedure, the Fund will pay the surgical fees charged for the procedure just as any other Major Medical service -- The Fund only will pay the Allowable Charge, which is the lesser of the amount that the Fund would have paid an Empire BlueCross/Blue Shield Preferred Provider for the procedure or the provider's actual charge for the procedure, and you will be responsible for the unpaid balance. Since Empire BlueCross/Blue Shield negotiates lower fees with the providers in its P.P.O., you likely will have to pay much more of the bill if you use a provider that is not part of the Empire BlueCross/Blue Shield P.P.O. While you are not required to get a second opinion before you have surgery, the Fund will cover the charges, under the Allowable Charge, if you decide to obtain a second opinion.

D. COVERED MAJOR MEDICAL EXPENSES

If you do not use an Empire Preferred Provider for your Major Medical claims, the Fund will only pay the Allowable Charge, which is the lesser of the amount that the Fund would have paid an Empire Preferred Provider for the procedure or the provider's actual charge for the procedure, and you will be responsible for the unpaid balance. Since Empire negotiates lower fees with the providers in its P.P.O., you likely will have to pay much more of the bill if you use a provider that is not part of the Empire P.P.O.

The following services and supplies are covered major medical expenses:

1. Charges by a Physician for medical care, treatment and surgery. In the event of surgery, some medical care by the surgeon may not be covered since the Plan's Allowable Charge includes certain pre-operative and post-operative care.
2. Surgical procedures performed at one time through the same incision are considered one surgical procedure. Payment is made for the procedure with the highest Allowable Charge at 100%, a second procedure paid at 50% of the Allowable Charge and the third and fourth procedure paid at 25% of the Allowable Charge. When a procedure code is submitted that is part of another major procedure code, only the major procedure code is reimbursed.
3. Charges by a Physician (other than the surgeon) for administration of anesthesia.
4. Charges for the following diagnostic tests (which are also provided by Empire at no out-of-pocket cost):
 - a. X-ray and laboratory;
 - b. Computerized Axial Tomography ("CAT scans"), except if ordered by a Chiropractor or Podiatrist;
 - c. Magnetic Resonant Imaging (MRI), except if ordered by a Chiropractor or Podiatrist;
 - d. Electromyography (EMG), except if ordered by a Chiropractor or Podiatrist;
 - e. Monitoring services (for example: EKG, EEG, Holter);
 - f. Audiologic function tests administered by a licensed Physician or audiologist;
 - g. Pulmonary;
 - h. Microbiology;
 - i. Vascular Diagnostics, except if performed or ordered by a Chiropractor or Podiatrist;
 - j. Cardiology.
5. Charges for the taking and interpreting of diagnostic procedures. If separate claims are submitted for the technical and professional component of one diagnostic procedure, the Fund allows 60% of the Allowable Charge for the technical component of the procedure and allows 40% of the Allowable Charge for the professional component, and then pays 80% of the Allowable Charge for each component. For example, if the Allowable Charge is \$100 and there are separate technical and professional charges, the technical component is given an allowance of \$60 and the professional component is given an allowance of \$40, which is then paid at 80% each, *i.e.*, \$48 for the technical provider and \$32 for the professional provider.
6. Charges for out-patient rehabilitation by a licensed physical therapist under the direction of a Physician are allowed, up to a limit of 36 visits per calendar year, if approved by the Fund in advance.
7. Charges for out-patient speech therapy rendered by a licensed therapist if referred by the Covered Person's Physician. If the purpose of the therapy is articulation, the Fund will only cover it if the deficiency is congenital in nature. For any other medical reason, such therapy must be approved in advance by the Fund. Treatment for stuttering is not covered.

8. Charges for ambulance service in connection with emergency room visit to a Hospital or admission as an in-patient (including Hospital transfers), when ordered by a Physician or a police officer, for transportation to the nearest Hospital where the required care can be provided. Ambulettes are not covered. Air ambulances are also covered if the Fund determines that the conditions for requiring an air ambulance transport are met. If these conditions are not met, but the Participant's condition did require transportation via a land ambulance, the Fund's coverage will be limited to the amount the Fund would have paid for a land ambulance.
9. Charges by a Dentist for treatment of natural teeth due to accident, provided that treatment to natural teeth must be completed within 12 months of the accident for the services to be covered
10. Rental (up to the purchase price) or purchase (if less expensive) of custom-made prosthetics, wheelchairs and other durable medical equipment and supplies for treatment of a specific Sickness or Injury, provided prior approval by the Fund is obtained. (Charges for some durable medical equipment such as oxygenators, are covered up to certain lifetime maximum limits. Please contact Empire BlueCross BlueShield for more details regarding these limits.)
11. Charges for blood transfusions by a Physician and the storage of blood or blood plasma.
12. Charges by a certified nurse-midwife who is permitted to perform the services under the laws of state where the services are rendered.
13. Charges for cardiac rehabilitation on an out-patient basis, provided prior approval by the Fund is obtained.
14. Charges for radiation therapy and/or chemotherapy.
15. Physician charges for in-patient rehabilitation for up to twenty (20) days per calendar year, provided prior approval by the Fund is obtained.
16. Services rendered by a Physician for acupuncture.
17. Charges for a nebulizer.
18. Charges for Physician services associated with kidney dialysis.
19. A glucometer is available without charge from Pharmacy Distributor Services.
20. If the Covered Person is receiving benefits in connection with a mastectomy, charges for: (a) reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications at all stages of mastectomy, including lymphedemas.
21. Charges for well woman visit/gynecological visit – one per calendar year.

E. WELL CHILD CARE

For Dependents who are children, the Fund covers routine office visits to a Physician, immunizations and laboratory tests in accordance with the Fund's Allowable Charge. Immunizations and well child care are covered until the end of the calendar year in which the child turns 14.

F. LIMITED COVERED MEDICAL EXPENSES: (Per Covered Person).

There is no double coverage if a husband and wife are both Eligible Retirees.

The following charges are covered as Limited Covered Medical Expenses to the extent

described below. Annual limits apply whether you use an Empire Preferred Provider or a non-Empire P.P.O. provider and once the annual limit is reached, the Fund will not pay for additional services. For example, if you reach your annual limit for Chiropractor services with a Empire Chiropractor, the Fund will not pay for additional visits to a non-P.P.O. Chiropractor.

1. Charges, by a Chiropractor in connection with the care of dislocations and subluxation of vertebrae, and manipulation of bone joints and soft tissues subject to the following limits:
 - a. The Fund will cover no more than one visit in one day;
 - b. The Fund will pay no more than \$750 per calendar year.Diagnostic tests performed or ordered by a Chiropractor are not covered except for plain radiographs. Plain radiographs ordered by a Chiropractor are Covered Medical Expenses.
2. Charges in connection with dermatology treatment will be paid up to a \$550 maximum per calendar year. In cases of burns, skin cancer, and extreme cases of psoriasis or eczema (as determined by the Fund), the Fund may grant an exception to this limit.
3. Charges in connection with immunotherapy for the treatment of allergies will be paid up to a \$550 maximum per calendar year.
4. Charges for Podiatric services will be paid up to a \$1,500 maximum per calendar year, except the following treatments are not covered:
 - a. Routine care or treatment of conditions for the feet such as corns, bunions (except capsular or bone surgery), callouses, removal of nails of the feet (except the removal of the entire nail), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This limit on podiatric services does not apply to Covered Persons whose treatment arises from diabetes;
 - b. Orthotics;
 - c. Casting, fabrication, and dispensing of orthotics;
 - d. Dispensing of surgical shoes. Jobst stockings are covered up to ten pair per year;
 - e. Surgical trays and sterile packs;
 - f. Out-patient operating room fees;
 - g. Fee for surgical assistant;
 - h. Post operative X-rays and serial X-rays during surgery
 - i. Injection of local anesthetic
 - j. Diagnostic tests performed or ordered by a Podiatrist are not covered, except for X-rays. X-rays ordered by a podiatrist are Covered Limited Medical Expenses.
5. Charges in connection with temporomandibular joint dysfunction (“TMJ”) when services are performed by a Physician will be paid up to \$5,000 maximum per lifetime;
6. Charges in connection with treatment for Mental Illness as follows:

- a. Out-patient charges by psychiatrist, psychologist or certified social worker are covered at 100% of the Allowable Charge, with no maximum visit limitation.
 - b. In-patient private Physician charges are covered on same terms as charges for any other illness.
7. Charges for Sclerosing and/or Ligation of Veins as follows:
- a. unilateral — maximum payment of \$1,680 per lifetime;
 - b. bilateral — maximum payment of \$1,881 per lifetime.
8. Charges for prosthetic wigs and toupees, up to a \$350 maximum every three years.
9. Charges for a Gardasil vaccine, up to 50% of Allowable Charge for each Gardasil vaccine you receive. If you use an Empire Preferred Provider, you will be responsible for the remaining 50% of the Allowable Charge as a co-payment. If you use an out-of-network provider, you will be responsible for the difference between the provider's billed amount and the 50% of the Allowable Charge that Empire would have paid one of its Preferred Providers, which may result in higher out-of-pocket expenses for you.

G. DIABETIC PROGRAM

Pharmacy Distributor Services provides a diabetic program for Fund Participants, which features the FreeStyle System for blood glucose testing. The FreeStyle monitor allows diabetics to test their blood sugar from their forearm or other parts of their body without the pain associated with traditional finger stick tests and also requires a much smaller drop of blood. Pharmacy Distributor Services will provide the meter to you for free and will also provide to you, by mail, covered diabetic supplies, excluding insulin, at no cost to you. For a brochure describing the meter and strips, and to speak with a Pharmacy Distributor Services representative, call 1-800-440-2417, Monday through Friday during the hours of 9.00 A.M. and 5.00 P.M.

H. DENIAL OR LOSS OF BENEFITS

In addition to the exclusions applicable to all forms of benefits under the Plan (Section 5), Major Medical benefits will not be paid for the following:

- 1. In-patient or out-patient facility charges (may be covered by Hospital benefits).
- 2. Charges for preventative, health, or check-up examinations, unless Medically Necessary for a Sickness or Injury, except for Well-Child Care, and any well woman visits/ gynecological visits.
- 3. Charges for dental work or treatment, except biopsies.
- 4. Charges for eye examinations, eyeglasses or contact lenses, and hearing aids; treatment of myopia and other errors of refraction; orthoptics or visual training; and the fitting or placing of eyeglasses or contact lenses.
- 5. Charges in connection with organ transplants if the procedure has not been approved by the Fund.
- 6. Charges for testing and treatment of infertility or for the promotion of conception or for artificial insemination or in-vitro fertilization or gamete intra fallopian transfer or similar or related procedures, or for reversal of voluntary sterilization or restoration of fertility or birth control, or for insertion or removal of IUD.

7. Charges for injections, except for those 1) allowed in connection with Well Child Care, 2) for tetanus shots in connection with an Injury and 3) for influenza vaccine for Covered Persons with cancer, heart disease, obstructive lung disease, asthma and patients with a history of pneumonia or immunosuppressed condition.
8. Charges for vitamin therapy or food supplements or dieticians.
9. Charges for Glucometer, Dextrometer, Tens Unit, and inhalation therapy in office.
10. Charges for Thermogram.
11. Charges for surgical appliances that are stock items and not made to order, such as braces, elastic supports and cervical collars.
12. Charges for common first-aid supplies such as adhesive tape, gauze, antiseptics, and ace bandages.
13. Charges for non-prescription drugs (except insulin for treatment of diabetes) and prescription drugs on the Federal DESI list of ineffective medicines.
14. Charges for membership fees, dues or any other charges in connection with recreational facilities, fitness, diet, stress management or nutritional centers, even if prescribed or recommended by a Physician.
15. Charges for facility fees (e.g. abortion clinics, surgical centers) (may be covered by Hospital Benefits).
16. Charges for treatment of sexual dysfunction not related to organic disease.
17. Charges for Home Health Care services performed by the Visiting Nurses Association and expenses for services performed by LPNs, Nurses Aides, Home Health Care Aides, Companions, or Housekeepers) (may be covered by Hospital Benefits).
18. Charges for sanitarium, custodial, convalescent, rest cure and non-skilled nursing care.
19. Charges for confinement in a Hospital, medical center or similar facility, or for any program or out-patient care for substance abuse.
20. Charges for a stand-by surgeon or stand-by anesthesiologist.
21. Charges for refractive keratoplasty services.
22. Charges for annual physicals, except as provided under the Well-Child Care Benefit. Please refer to Section E.

III. HOSPITAL AND MEDICAL BENEFITS FOR POST-65 RETIREES

Hospital Benefits and Medicare

Please remember that, if you are eligible for Medicare, the Fund will pay Hospital Benefits secondary to Medicare. Be aware that Medicare helps you to pay Hospital bills but it does not pay your bills in full. There are Medicare deductible and coinsurance amounts that you must pay. These Medicare deductible and coinsurance amounts are subject to change by the government. Generally, this plan will pay the co-insurance and any deductibles for which you are responsible under Medicare as a result of a hospitalization, including co-insurance or deductibles arising from any Lifetime Reserve days. Generally, though, the Fund will pay the lower of Medicare's charge for the service or the Fund's Allowable Charge.

In order to qualify under your Plan for co-pay and deductible benefit amounts, you must apply for and carry both Part A and Part B of Medicare.

The following describes the hospital services covered by the Fund after coordinating with Medicare as the primary payer for these services:

A. IN-PATIENT SERVICES

1. Room and Board. The Fund will cover up to one hundred twenty (120) days of Room and Board.

The Fund will cover 120 days of Room and Board during a single hospitalization or during several separate hospitalizations, as long as there are fewer than 90 days between admissions. If there is more than 90 days between admissions, a new 120-day period will begin with the next hospitalization. After you have used the 120 days of Room and Board, there must be at least a ninety (90) day period of separation between hospitalizations before another period of hospitalization will be covered.

Semi-private Accommodations: If you or your Eligible Dependent is a Hospital patient in a semi-private room, Room and Board and general nursing care are covered for up to 120 days.

Private Accommodations: If you or your Eligible Dependent is a Hospital patient in a private room, the Plan provides for a daily allowance equal to the Hospital's average semi-private room charge for Room and Board and general nursing care.

2. Other Hospital Services. You and your Eligible Dependents are covered for the following services:

- a. Use of operating and cystoscopic rooms and equipment;
- b. Use of recovery room and equipment;
- c. Laboratory examinations;
- d. X-ray examinations;
- e. All drugs and medicines for use in the Hospital, including radium or radioactive substances, which are commercially available for purchase and readily obtainable by the Hospital;
- f. Blood, blood storage, use of blood transfusion equipment and administration of blood or blood derivatives when given by a Hospital employee;
- g. Oxygen and use of equipment for its administration;
- h. Anesthesia supplies and use of anesthesia equipment;
- i. Dressings and plaster casts;
- j. Use of cardiographic equipment;
- k. Physiotherapeutic and hydrotherapeutic treatments when administered by a Hospital employee;
- l. Charges for radiation therapy and/or chemotherapy; and
- m. Out-patient diagnostic testing.

B. OUT-PATIENT SERVICES

Hospital benefits are provided in the event you or your Eligible Dependent is not admitted as a bed patient but receives care in a Hospital emergency room or operating room for:

1. **Emergency Treatment and/or Ambulatory Surgery.**
 - a. Emergency first aid during the first visit for treatment of an accidental Injury within 72 hours following such Injury;
 - b. Emergency care during the first visit for treatment within twelve (12) hours of the onset of Sudden Serious Sickness or Injury;
 - c. Ambulatory minor surgery, defined as surgery for which the patient is discharged on the same day as the surgical procedure.

2. **Presurgical Testing.**
 - a. Hospital benefits are provided for diagnostic tests when they are prescribed by your Physician as a preliminary to scheduled surgery, are given within fifteen (15) days prior to scheduled surgery, and are performed in the same Hospital in which the surgery is performed.
 - b. Hospital benefits for out-patient services, will be provided for up to a total of thirty (30) visits per calendar year, except for dialysis. Ambulatory surgery will be covered under the same benefits and limitations as in-patient surgery.

3. **Out-Patient Chemotherapy.** Hospital benefits are provided for out-patient chemotherapy administered by a Hospital employee including medications.

4. **Mammography Screening.** Hospital benefits are provided for mammography screening upon a Physician's request.

5. **Colonoscopies.** Facility and physician fees for colonoscopies are covered only to the extent of the Allowable Charge for the procedure if it is performed in a doctor's office or in a Hospital.

C. SPECIAL CONDITIONS

1. Mental or Nervous Disorders.

Hospital benefits for mental or nervous disorders are available up to 120 days during a single hospitalization or during several separate hospitalizations, as long as there are fewer than 90 days between admissions, in any Hospital in which Hospital benefits are provided, and in any separate, psychiatric division of any general Hospital. If there is more than 90 days between admissions, a new 120 day period will begin with the next hospitalization. After you have used the 120 days, there must be at least a ninety (90) day period of separation between hospitalizations before another period of hospitalization will be covered.

2. Dialysis for Kidney Failure.

Hospital benefits are provided for hemodialysis or peritoneal dialysis while you or your Dependent are a registered bed patient in a Hospital.

Hospital benefits are also provided for out-patient dialysis, as follows:

- a. For dialysis at home, the Fund will pay the cost of all appropriate and necessary supplies as well as the Allowable Charge for rental cost of the required equipment and the attending nurse.
- b. For dialysis at a Hospital or freestanding facility, the Fund will pay the cost of treatment of the Hospital's or facility's dialysis program.

D. HOSPICE CARE

You and your Eligible Dependents have coverage for up to 210 days of in-patient hospice care in a hospice or Hospital, and home care and out-patient services provided by the hospice as described below if:

1. The hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law; or if the hospice is located outside of New York State, under a similar certification process required by the state in which the hospice organization is located and the Covered Person has been accepted by the hospice program for such care; and
2. The Covered Person has been certified by such covered hospice as having a life expectancy of six (6) months or less.

Covered hospice services include:

1. Bed patient care either in a designated hospice unit or in a regular Hospital bed, and day care services provided by the hospice organization.
2. Home care and out-patient services provided by the hospice and charged to the Covered Person including:
 - a. Intermittent care by a registered nurse (R.N.), licensed practical nurse (L.P.N.) or Home Health Aide;
 - b. Physical therapy;
 - c. Speech therapy;
 - d. Occupational therapy;
 - e. Respiratory therapy;
 - f. Social services;
 - g. Nutritional services;
 - h. Laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms;
 - i. Medical supplies;
 - j. Drugs and medications prescribed by a Physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary; (not covered when the drug or medication is of an experimental nature);
 - k. Medical care provided by the hospice Physician;
 - l. Five visits for bereavement counseling for the Covered Person's family either before or after the Covered Person's death;
 - m. Durable medical equipment provided prior Fund approval is obtained;
 - n. Transportation between home and Hospital or hospice organization provided such transportation is Medically Necessary.

E. ORGAN TRANSPLANTS

Where the organ transplant procedures are determined by the Plan to be experimental in nature or obsolete, benefits are not payable under the Plan. For Hospital benefits to cover organ transplants, prior written approval must be obtained from the Fund, and the transplant must take place at a facility approved by the Fund for that procedure.

If the recipient of the organ is a Covered Person, Hospital Benefits for approved organ transplants include costs related to the donation of an organ used in the transplant

procedure, such as Hospital charges to obtain, store and transport the organ, as long as no other coverage is available from other sources.

The Covered Expenses of the organ donor, if the donor is a Covered Person under the Plan, will be paid in accordance with the Allowable Charge, even if such expenses would not be covered because such surgery could be determined to be not Medically Necessary for the donor. The Covered Expenses of the organ donor, if the donor is not a Covered Person under the Plan, will be paid in accordance with the Allowable Charge only if health coverage is unavailable from all other sources.

Transplants of animal organs or parts are excluded from coverage.

Where other funding (such as government or institutional sources) is available for an organ transplant, the Fund is the secondary payor and all other sources of funding must be exhausted before the Fund is obligated to pay benefits.

OTHER MEDICAL BENEFITS FOR POST-65 RETIREES

Generally, with respect to Medicare Part B claims, the Fund will pay the 20% of the medical bills that Medicare does not cover. In addition, the Fund will cover the annual deductible as it applies to covered benefits, subject to the limitations and exclusions set forth above.

Reminder: If you or your eligible dependent become eligible for Medicare coverage, you must enroll in both Medicare Part A and Part B. **IF YOU FAIL TO ENROLL IN MEDICARE PART A or B, BENEFITS WILL ONLY BE PAID AS IF YOU WERE ENROLLED IN MEDICARE AND MEDICARE MADE A PAYMENT UNDER PART A OR B.**

The following services and supplies are covered medical expenses after coordinating with Medicare as primary payer for these services:

1. Charges by a Physician for medical care, treatment and surgery. In the event of surgery, some medical care by the surgeon may not be covered since the Plan's Allowable Charge includes certain pre-operative and post-operative care.
2. Surgical procedures performed at one time through the same incision are considered one surgical procedure. Payment is made for the procedure with the highest Allowable Charge at 100%, a second procedure paid at 50% of the Allowable Charge and the third and fourth procedure paid at 25% of the Allowable Charge. When a procedure code is submitted that is part of another major procedure code, only the major procedure code is reimbursed.
3. Charges by a Physician (other than the surgeon) for administration of anesthesia.
4. Charges for the following diagnostic tests (which are provided by the Fund Office at no out-of-pocket cost):
 - a. X-ray and laboratory;
 - b. Computerized Axial Tomography ("CAT scans"), except if ordered by a Chiropractor or Podiatrist;
 - c. Magnetic Resonant Imaging (MRI), except if ordered by a Chiropractor or Podiatrist;
 - d. Electromyography (EMG), except if ordered by a Chiropractor or Podiatrist;
 - e. Monitoring services (for example: EKG, EEG, Holter);

- f. Audiologic function tests administered by a licensed Physician or audiologist;
 - g. Pulmonary;
 - h. Microbiology;
 - i. Vascular Diagnostics, except if performed or ordered by a Chiropractor or Podiatrist;
 - j. Cardiology.
5. Charges for the taking and interpreting of diagnostic procedures. If separate claims are submitted for the technical and professional component of one diagnostic procedure, the Fund allows 60% of the Allowable Charge for the technical component of the procedure and allows 40% of the Allowable Charge for the professional component, and then pays 80% of the Allowable Charge for each component.
 6. Charges for out-patient rehabilitation by a licensed physical therapist under the direction of a Physician is allowed twice weekly for up to two (2) weeks, i.e., 4 visits per calendar year.
 7. Charges for blood transfusions by a Physician and the storage of blood or blood plasma.
 8. Charges for cardio rehabilitation on an outpatient basis, up to a maximum of ninety visits per calendar year.
 9. Charges for radiation therapy and/or chemotherapy.
 10. Services rendered by a Physician for acupuncture.
 11. Charges for Physician services associated with kidney dialysis.
 12. If the Covered Person is receiving benefits in connection with a mastectomy, charges for: (a) reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications at all stages of mastectomy, including lymphedemas.
 13. Charges for outpatient physical therapy by a licensed therapist under direction of a Physician up to four (4) visits per calendar year.
 14. Charges for allergy treatments up to sixteen (16) visits per calendar year.
 15. Charges for temporomandibular joint disorder (“TMJ”), up to \$5,000 per lifetime.
 16. Charges for a well woman visit: with a condition – one per calendar year; without a condition – one every two years (per Medicare Guidelines)

**LIMITATIONS AND EXCLUSIONS FOR POST 65-RETIREE
MEDICAL BENEFITS**

In addition to the exclusions applicable to all forms of benefits under the Plan (Section 5), Hospital and Medical benefits will not be paid for Post-65 Retirees for the following:

1. Charges for durable medical equipment (“DME”) and supplies.
2. Charges for skilled nursing facility and home care.
3. Charges for diabetic supplies – Including diabetic shoes or Una Boot.
4. Charges for ambulance services and air ambulance.
5. Charges for consultation fee by a physician who acts as the surgeon.

6. Charges for chiropractic services.
7. Charges for injections (except for bursa or joint injections).
8. Charges for Assistant Surgeons (except for open heart surgery).
9. Charges for standby physicians at surgery including Cardiologists, Surgeons, Internists.
10. Charges for standby anesthesiologists.
11. Charges for in-patient private duty nursing.
12. Charges for prescription drugs and non-prescription drugs.
13. Charges for eye examinations, eyeglasses or contact lenses, treatment of myopia and other errors of refraction (including keratoplasty services); orthoptics or visual training; and the fitting or placing of eyeglasses or contact lenses.
14. Charges for urinalysis measurement.
15. Charges for venipuncture.
16. Charges for confinement in a Hospital, medical center or similar facility, or for any program or out-patient care for substance abuse.
17. Charges for sleep disorder testing machine.
18. Charges for annual physical health check-ups.
19. Charges for hearing aids.
20. Charges for immunizations, except for influenza vaccine for Covered Persons with hypertension, diabetes or cancer.
21. Charges of inpatient rehabilitation services.
22. Charges for vitamin therapy or food supplements or dieticians.
23. Charges for membership fees, dues or any other charges in connection with recreational facilities, fitness, diet, stress management or nutritional centers, even though prescribed or recommended by a Physician.
24. Charges for treatment of sexual dysfunction not related to organic disease.
25. Charges in connection with organ transplants if the procedure has not been approved by the Fund.

IV. PRESCRIPTION DRUG BENEFIT (FOR PRE-65 RETIREES ONLY)

This benefit applies to Pre-65 Retirees only. The Fund has a contract with Systemed/Medco Health to have prescriptions filled at a pharmacy or by mail order. However, unlike the Active Plan, there is a \$1,000 per calendar year benefit limit for each Eligible Retiree and Dependent under this Plan. Otherwise, the benefit is identical to the prescription drug benefit you were receiving when you were covered under the Active Plan.

A. RETAIL PHARMACY SERVICE

By using your prescription drug program identification card, you can obtain medication from a participating retail pharmacy. You can obtain up to a 30-day supply of covered medication. You pay a \$5 co-payment for generic drugs and a \$15 co-payment for brand-name drugs. Refills will be provided in accordance with the prescription and state law. For a prescription you take on an ongoing basis (more than three months), you may use a participating retail pharmacy for your initial prescription and up to two refills (for a total of three fills), for up to a 30-day supply each time. If you remain

on that drug, you must order subsequent refills through the Home Delivery Pharmacy Service (described below) or pay a higher co-payment for each prescription filled at a retail pharmacy. The higher co-payment is \$20 per prescription for generic drugs and \$60 for brand-name drugs.

In the event that you do not use a participating pharmacy, you should obtain a receipt and apply to Medco Health for direct reimbursement. You can order claim forms and envelopes through Medco Health's website, www.medcohealth.com, or by calling (800) 711-0917. The reimbursement schedule for a direct reimbursement is the same as the reimbursement of a participating pharmacy. Therefore, if you submit for direct reimbursement, the amount you are reimbursed may not be the full amount that you paid towards the medication.

B. THE MEDCO HOME HEALTH DELIVERY PHARMACY SERVICE

If you or your Dependents have a chronic condition that requires long-term medications (such as high blood pressure, heart conditions, diabetes, etc.), use the Home Delivery Pharmacy Service. You pay your applicable co-payment for up to a 90-day supply of generic or brand medications. You pay a \$10 co-payment for generic drugs and a \$30 co-payment for brand-name drugs.

To order new prescriptions through the Home Delivery Pharmacy Service, follow these easy steps:

Option 1 — Mail in your prescriptions:

- Step 1. Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (as appropriate). Make sure you have a 2-week supply on hand. If not, ask your doctor for a 30-day prescription that you can fill at a participating retail pharmacy while you wait for your home delivery prescription to arrive.
- Step 2. Mail the new prescription using a Medco Health mail order form and envelope. If you need to request order forms and envelopes, go online anytime at www.medcohealth.com or call Member Services toll-free at 800-711-0917.

Your prescription order will be delivered to you within 7 to 11 days after you mail in the order.

Option 2 — Have your doctor fax your prescriptions:

- Step 1. Follow Step 1 in the Mail section above.
- Step 2. Provide your doctor with your Member ID number (located on your prescription ID card) and ask him or her to call 1-888-327-9791 for instructions on how to use Medco's fax service. You will be billed later.

Your prescription order will be delivered to you within 5 to 8 days after your doctor faxes the order.

To order additional refills through the Home Delivery Pharmacy Service:

- Call 1-800 4REFILL (1 800 473-3455) to use the automated refill system; or
- Mail your refill slip and appropriate co-payment in the special order envelope; or
- Visit the Medco Health website at www.medcohealth.com to order online.
- Your order will be processed promptly — usually within 48 hours of receipt and your medication will be sent to you via U.S. Mail or UPS along with instructions for

future refills, if applicable. After processing, please allow approximately one week for normal mail delivery.

- You may check the status of your order by visiting the Medco Health website at www.medcohealth.com or by calling Member Services at 800-711-0917.
- If you are provided mail-order pharmacy drugs and you did not make a co-payment, you are still responsible for making a co-payment for those drugs. Failure to do so may result in your suspension from the mail-order pharmacy program.

Important Phone Numbers: If you have any questions about the prescription drug program or about the time of delivery for your mail order prescriptions, you can contact Medco Health during regular business hours by calling toll free (800) 711-0917 or the Fund Office at (718) 845-5800. You also can contact Medco Health through their website, www.medcohealth.com.

C. COVERED PRESCRIPTION MEDICINES

The following are covered by the Prescription Drug Benefit:

1. Federal Legend Drugs;
2. State restricted drugs;
3. Insulin and Luprin by prescription;
4. Compounds that include at least one prescription drug item;
5. Syringes and needles by prescription for diabetes; and
6. Retin A and similar products up to 26th birthday.
7. Injectables (via Mail Order Only), upon approval by the Fund.

D. EXCLUDED PRESCRIPTION DRUGS

The following are excluded by the Prescription Drug Benefit:

1. Non-prescription items (such as bandages, heating pads, aspirin, etc.) even if a Physician may order them on a prescription pad;
2. Fertility medications;
3. Oral contraceptives (unless prescribed for non-contraceptive medical purposes), jellies, creams, foams or devices;
4. Implements and any other surgical supplies or devices;
5. Retin A (after patient's 26th Birthday);
6. Rogaine for baldness, or any drugs whose sole purpose is to promote or stimulate hair growth;
7. Smoking Deterrents;
8. Syringes and needles other than insulin syringes and needles;
9. Drugs labeled "Caution-limited by Federal Law to investigational use", or Experimental drugs, even though a charge is made to the individual;
10. Food supplements;
11. Non-Federal Legend Drugs;
12. Immunization agents, biological sera, blood or blood plasma;
13. Therapeutic devices or appliances;
14. Medication that is to be taken by or administered to a Covered Person, in whole or in part, while he or she is an in-patient in a Hospital or other similar

institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

15. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order;
16. Expense due to Injury or Sickness that arises out of or in the course of employment;
17. Charges for the administration of any drug;
18. Diagnostic agents;
19. Prescription drugs listed on the Federal DESI list of ineffective medicines;
20. Drugs used to treat sexual dysfunction; and
21. Vitamins that do not carry the Legend: "Caution — Federal (U.S.A.) law prohibits dispensing without a prescription."

V. MEDICARE PART D REIMBURSEMENTS (FOR POST-65 RETIREES ONLY)

The Fund will reimburse post-65 Retirees and their spouses for \$25.00 of the monthly expenses they pay for any premium-based prescription drug plan offered by Medicare, including a Medicare Part D Plan. You will be asked to provide proof in the form of your Medicare prescription drug card and an Explanation of Benefits from your insurance carrier demonstrating your prescription drug coverage. Upon request, you and/or your spouse will have to send the Fund Office proof that you still participate in a prescription plan every calendar year. Otherwise, no reimbursement will be provided.

SECTION 5 EXCLUSIONS AND LIMITATIONS

Each benefit section of this Summary Plan Description may contain limitations and exclusions applicable to that particular benefit. **Listed below are limitations, exclusions, and circumstances applicable to all benefits except as indicated under each Section.**

No benefits will be paid by the Fund for:

- A. Any charge, or part of a charge, for which mandatory automobile no-fault benefits are recovered or recoverable, including instances in which coverage is denied by the no-fault carrier if, for example, (1) you or your Dependent are injured while operating a motor vehicle in an intoxicated condition, (2) for charges for a No-Fault Insurance deductible, (3) for charges incurred if you are injured as a passenger in an uninsured vehicle. This exclusion does not apply to Weekly Disability Benefits.
- B. Charges in connection with a Sickness or Injury that was deliberately self-inflicted, including any suicide attempts or threats.
- C. Charges resulting from you or your Dependent's participation in an illegal, criminal or violent act, a domestic dispute or while in police custody. However, injuries resulting from an act of domestic violence or from a medical condition, including mental health conditions, are not excluded solely because the source of the injury was an act of domestic violence or a medical condition.
- D. Charges for any Sickness or Injury resulting directly or indirectly from your intoxication due to a drug, narcotic or any other intoxicant.
- E. Services that are not Medically Necessary.

- F. Elective cosmetic surgery, except for reconstructive surgery that is part of an operation to treat an infection, injury or a disease, or that follows such an operation. This exclusion does not apply, in connection with a mastectomy, to reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- G. (1) Services usually provided without charge, (2) charges that would not have been made if coverage had not existed, (3) any charges that the Participant or Eligible Dependent is not required to pay, or (4) for which a claim is not filed within the deadline specified in Section 12.
- H. Charges paid for by any other person or entity.
- I. To the extent allowed by law, any claim for services provided by a Veterans Administration, Federal, State or any other Hospital operated by a governmental unit, unless a charge is made that the Covered Person is legally required to pay without regard to the existence of coverage.
- J. Charges for any services rendered by the claimant's Immediate Family.
- K. Charges for Experimental or obsolete procedures or drugs.
- L. Charges for services if you or your Dependent were not eligible for benefits at the time the claim was incurred.
- M. Charges for services if you or your Dependent failed to submit required evidence to support the claim.
- N. Charges for services if you or your Dependent made material misstatements in connection with eligibility or the claim.
- O. Charges for services if you or your dependent omitted facts or material statements as to other coverage available to you.
- P. Charges for services provided to you or your eligible dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your dependent, or you or your dependent's attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, as provided in Section 14.

For any mental health benefits provided under this Plan, any processes, strategies, evidentiary standards, or other factors used to determine any nonquantitative treatment limitation (such as a medical necessity determination) as applied to mental health benefits will be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used to determine any nonquantitative treatment limitation for medical/surgical benefits, except when recognized clinically appropriate standards of care permit a difference.

SECTION 6 SUSPENSION OF BENEFITS

Your Retiree Benefits will be suspended if your pension benefits are suspended under the provisions of the Division 1181 A.T.U. — New York Employees Pension Plan. Your eligibility for Retiree Benefits will be reinstated when and if your pension benefit is reinstated.

SECTION 7 COORDINATION OF BENEFITS

This provision is intended to prevent the Fund from duplicating payments that you may be entitled to under other plans or insurance policies. When you or any of your Dependents are eligible to receive benefits under any other health plan, benefits provided under Division 1181 A.T.U.-New York Welfare Fund will be coordinated with benefits from the other health plan(s) so that, when added together, up to 100% of the Allowable Expenses incurred during a calendar year will be paid by all health plans. **However, this Plan will never pay, either as the primary or secondary plan, more than what the Plan would have paid if there were not other plans involved.** All benefits provided by the Plan (excluding life insurance) are subject to the Coordination of benefits rules.

A. DEFINITIONS FOR COORDINATION OF BENEFITS

In applying the Coordination of Benefits rules, the following definitions apply:

Health plan means (a) any group insurance coverage, (b) an employer-sponsored Blue Cross, Blue Shield, or other pre-payment coverage, (c) any coverage under labor-management trustee plans or employee benefits organization plans, including this Plan, (d) any coverage under government programs, (e) any coverage required or provided by statute (except Medicaid), (f) any mandatory “no-fault” coverage, and (g) student coverage obtained or offered by an educational institution.

The term **health plan** is applied separately to each such policy, contract or arrangement for benefits and separately with respect to that portion of any policy, contract or other arrangement that reserves the right to take the benefits and that portion which does not reserve such right.

Allowable Expense means any service covered all or in part under at least one of the health plans covering the person for whom the claim is made.

Claim Determination Period means a calendar year or that portion of a calendar year during which the Covered Person is covered under this Plan.

B. THE RULES FOR DETERMINING WHICH PLAN HAS THE PRIMARY RESPONSIBILITY FOR YOUR BENEFIT PAYMENT ARE AS FOLLOWS:

1. If one health plan does not have a Coordination of Benefits provision, it will automatically be primary.
2. If you are covered as an employee, former employee, or retiree under one health plan and are covered as a dependent under the other health plan, then the health plan covering you based on your employment is primary.

Examples of Rule 2 are as follows:

If you are an Eligible Retiree (not Medicare eligible) and your spouse is an Eligible employee under this Plan:

For you: Your retiree coverage is primary and your spouse’s active Dependent coverage is secondary;

For your spouse: This Plan’s active employee coverage is primary and your retiree dependent coverage is secondary.

If you are an Eligible Retiree (with Medicare) and your spouse is a Dependent under this Plan and has no other coverage:

For you: Medicare is primary and your retiree coverage is secondary;

For your spouse: This Plan's Dependent retiree coverage is primary.

If you are an Eligible Retiree with Medicare, and your spouse has retiree coverage under another health plan and Medicare:

For you: Your primary coverage is Medicare, this Plan's retiree coverage is secondary; and

For your spouse: Your spouse's primary coverage is the other retiree health plan, Medicare is secondary, and your retiree dependent coverage pays third.

If you are an Eligible Retiree and your spouse has retiree coverage under another health plan (not Medicare eligible):

For you: Your retiree coverage under this Plan is primary, your spouse's retiree dependent coverage is secondary; and

For your spouse: Your spouse's retiree coverage is primary, and your retiree Dependent coverage is secondary.

If you are an Eligible Retiree with retiree coverage under another health plan (not Medicare eligible):

For you: The retiree plan under which you were covered the longest period of time is primary, the other retiree coverage is secondary.

If you are an Eligible Retiree with other retiree coverage, e.g. NYC, and Medicare:

For you: Medicare is primary, the retiree plan under which you were covered the longest period of time is secondary, and the other retiree health plan pays third.

3. If you are covered as an active employee under a health plan and you are also covered as a retired/laid-off employee under another health plan, the health plan covering you as an active employee is primary. An example of Rule 3 is as follows:

If you are an Eligible Retiree and you also have active coverage as an employee under another health plan:

Your active coverage under the other health plan is primary, and your retiree coverage under this Plan is secondary.

4. If you are a Dependent child who is covered under the plans of both parents, the plan of the parent whose birthday falls earlier in the calendar year is primary. If both parents have the same birthday (only the month and day are considered), the health plan that covered a parent for a longer time is primary. If one health plan does not have this rule, but instead has a rule based on the gender of the parent, and as a result the health plans do not agree on which is primary, then the father's health plan is primary.

5. If the patient is a Dependent child and the parents are divorced or separated, then the following rules apply:

- a. If a court decree has established which parent has financial responsibility for the child's health care expenses, then that parent's health plan is primary;

- b. If financial responsibility has not been legally established, then the health plan that covers the child of the parent with custody is primary;
 - c. If the parent with custody remarries and the child is covered as a dependent under the plan of the stepparent, the order of primacy is as follows:
 - i. the parent with custody,
 - ii. the stepparent,
 - iii. the parent without custody.
6. If none of the above apply, then the plan under which the patient has been enrolled the longest is primary.
 7. The Plan will pay only in accordance with these rules and the rules of other health Plan(s) will not change the order in which this Plan will pay.
 8. If a Dependent has other coverage such as H.I.P., HMO or any other managed care group using panel Physicians, and chooses not to use the coverage, no Plan benefits will be paid. If the Fund is the secondary payor and the primary payor is a health maintenance organization or preferred provider organization, then the Fund assumes that the primary payor pays the full value of the services and the Fund is secondary only for any deductible or co-payment under the primary coverage.

C. RULES ON COORDINATION OF BENEFITS

This provision applies in determining the benefits for a Covered Person for any Claim Determination Period. Benefits payable under other health plans include the benefits that would have been payable had a claim been made.

If this Plan is **primary**, the Plan will process the claim under the terms of this Plan as if you or your Dependent were not eligible to receive benefits under another health plan. What the other health plan pays depends on their coordination of benefit rules.

If this Plan is **secondary**, the following rules will apply:

1. If the other health plan that is the primary plan has paid the same or more than this Plan would pay as primary, this Plan will pay 20% of the Allowable Charge under this Plan for the claim.

Example #1: Claim is \$400. Other health plan has paid \$300. This Plan's Allowable Charge is \$200.

Since the other health plan has paid more than this Plan would have paid as primary, this Plan will pay \$40 (20% of the Allowable Charge under this Plan) for the claim.

2. If the other health plan that is the primary plan has paid less than this Plan would pay as primary, this Plan will pay any balance on the claim remaining, up to 100% of the Allowable Charge under this Plan for the claim. That means that this Plan will pay the difference between what the other health plan has paid and 100% of the Allowable Charge under this Plan for the claim.

Example #1: A Claim is \$400. Other health plan has paid \$100. This Plan's Allowable Charge is \$200.

Since the other health plan has paid less than this Plan would have paid as primary, this Plan will pay \$100 (the difference between \$100 – what the other health plan has paid and \$200 – 100% of the Scheduled Allowance under this Plan) for the claim.

Remember -- Coordination of benefits helps you and the Plan save money. Without coordination, this Plan would have paid \$200 – the Allowable Charge under this Plan – in these examples. As you can see from these examples, with Coordination of Benefits between this Plan and the other health plan, more of your claim gets paid!

To ensure that the Fund coordinates benefits with any other health plan coverage you have, you must keep the Fund informed of any and all coverage for you and your Dependents.

SECTION 8 COORDINATION OF BENEFITS WITH MEDICARE

If you or your spouse is eligible for Medicare, you (or your spouse) must enroll in both Medicare Parts A and B as soon as you are eligible. If you fail to enroll in both Medicare Part A and B, benefits will be paid as if you were enrolled in Medicare and Medicare had made a payment under Part A or B. In all circumstances, (i.e., whether you are a pre- or post-65 Retiree), if you are enrolled in Medicare, Medicare will be the primary payer and the Plan will be secondary.

End Stage Renal Disease

If you have End Stage Renal Disease, the Retiree Benefits under this Plan will be primary for the first 30 months of treatment, to the extent required by law. After the 30-month period, regardless of your age, Medicare becomes primary and the Plan is secondary. Please consult the Fund Office for a more detailed explanation if this rule may apply to you.

SECTION 9 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, allows Dependents of Retirees to pay for a temporary extension of health coverage of Retiree Benefits (called “Continuation Coverage”) at group rates in certain instances, called “Qualifying Events,” where coverage under the Plan would otherwise end. Continuation Coverage will include all benefits the Covered Person was entitled to before the Qualifying Event, except Life Insurance. A Retiree is not entitled to Continuation Coverage for Retiree Benefits if coverage ends for any reason, including because the person does not pay the co-payment.

When you terminated Eligible Employment and retire, you may either elect to receive COBRA Continuation Coverage under the Active Benefit Plan or Retiree Benefits Plan. (Please refer to the Active Benefits SPD for more details regarding the election of COBRA coverage under the Active Benefits Plan). If you elect to receive COBRA Continuation Coverage, you will be eligible to receive Retiree Benefits when your COBRA Continuation Coverage terminates. Once you begin receiving Retiree Benefits under the Fund, COBRA Coverage for Active Benefits will no longer be available to you.

Qualifying Events

Your Dependents have the right to elect COBRA Continuation Coverage for Retiree Benefits for the following Qualifying Events if it results in the loss of Dependent

Retiree Benefits: death of the Eligible Retiree, legal separation or divorce from the Eligible Retiree, a Dependent ceasing to be a Dependent under the terms of the Plan, or the bankruptcy of the Employer from whose employment the Retiree retired. Loss of coverage due to failure to pay the co-payment is not a Qualifying Event.

Reporting Requirements

You or the Dependent (spouse or child) as applicable, must notify the Fund Office in writing of the following Qualifying Events within sixty (60) days after the occurrence of the Qualifying Event:

1. Divorce or legal separation of the Retiree from the Dependent spouse; or
2. A Dependent ceasing to be a Dependent under the terms of the Plan; or
3. The death of the Retiree.

If you or your Dependent fail to furnish such notification within the required sixty (60) days, the Dependent will lose the right to Continuation Coverage.

Notices should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, at the following address: Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Boulevard, Ozone Park, New York 11416. Written notice of a qualifying event must include the following information: name and address of the Eligible Retiree and Dependent, Retiree's Social Security number, and date of occurrence of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of the divorce decree, separation agreement, death certificate, dependent's birth certificate). Once the Fund receives timely notification that a qualifying event has occurred, COBRA coverage will be offered to Dependents, as applicable.

It is crucial that Retirees and Dependents keep the Fund informed of their current addresses. If you or a Dependent experience a change of address, immediately inform the Fund Office, in writing, at the above address. Retirees should also keep a copy of any notices they send to the Fund Office for their records.

Financial Responsibility for Failure to Give Notice

If a Dependent fails to give proper notice within sixty (60) days of the date of the Qualifying Event and, as a result, the Fund pays a claim for a Dependent whose coverage terminated due to a Qualifying Event and who does not elect Continuation Coverage under this provision, then the Retiree and Dependent will be obligated to reimburse the Fund for any claims that should not have been paid. If the Dependent fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on your behalf or for any of your Dependents.

In addition, you or your Dependent must notify the Fund Office immediately if you become covered by any other group health benefits whether through your employment or your spouse's employment or otherwise. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Notice and Election Form

Empire will, within fourteen (14) days of receiving notification of a Qualifying Event, send to the Dependent a COBRA Notice and Election Form. This form will describe the coverage available, the cost, and the conditions under which the Continuation Coverage will terminate. In order to obtain COBRA Continuation Coverage, the

Notice and Election Form must be completed and returned to Empire Blue Cross Blue Shield or the Fund Office within sixty (60) days of receipt. Payment of the COBRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within forty-five (45) days after the return of the completed COBRA Notice and Election Form. COBRA Notice and Election Forms must be sent to the following address: Empire Blue Cross Blue Shield, P.O. Box 660350, Dallas, TX 75266-0350.

Coverage may be continued for any Dependent who is properly enrolled on the day before the Qualifying Event resulting in loss of eligibility (listed above). Each Dependent who is not a minor has the independent right to elect or reject COBRA Continuation Coverage. The Eligible Retiree may elect coverage on behalf of his or her spouse and family members. An election on behalf of a Dependent child can be made by the child's parent or legal guardian.

Details of Continuation Coverage

If your Dependent chooses Continuation Coverage, the coverage provided is identical to the Retiree Benefits coverage provided under the Plan to similarly situated Dependents. If the coverage provided under the Plan is modified after your Dependent elects Continuation Coverage, his or her coverage will also be modified.

Your Dependent does not have to show that he or she is in good health to elect Continuation Coverage. However, under COBRA, your Dependent will have to pay the cost for the Continuation Coverage.

Payment Provisions

COBRA Continuation Coverage requires timely application for coverage and timely monthly payments. The payment due date is the first day of the month in which COBRA Continuation Coverage begins. For example, payments for the month of November must be paid on or before November 1st. The Payment due for the initial period of COBRA Continuation Coverage must include payment for the period of time dating back to the date that coverage would have terminated if your Dependent(s) had not elected COBRA Continuation Coverage. If your Dependent fails to pay the full payment by each due date (or within the 30-day grace period), he or she will lose all COBRA Continuation Coverage. Payments due under COBRA coverage must be made to the following address: Empire Blue Cross Blue Shield, P.O. Box 14258, Orange, CA 92863-1258.

Once a timely election of Continuation Coverage has been made, it is the responsibility of your Dependent(s) seeking Continuation Coverage to make timely payment of all required payments. The Fund will not notify you and/or your Dependent(s) that a payment is due or that it is late. Further, the Fund will not notify you and/or your Dependent(s) that Continuation Coverage is about to be, or has been terminated due to the untimely payment of a required payment.

Cost of COBRA Coverage

Your Dependent must pay benefits, as determined by the Fund; the cost will not exceed 102% of the cost of coverage. The cost will be specified in the COBRA Notice and Election Form sent to you by Empire. If your former Employer alters the level of benefits provided through the Fund to similarly situated active employees, your Dependents' COBRA coverage and cost also will change.

The Trustees will determine the cost for the continued coverage. The cost can change to reflect a change in coverage, a change in administration, annually or as otherwise permitted by law.

Continuation Period

Premiums will be accepted and coverage continued for up to 36 months from the date of the qualifying event.

Termination of COBRA Coverage

COBRA Continuation Coverage will terminate on the first of the following dates:

1. The date that the Fund terminates or no longer provides Retiree Benefits to similarly situated Dependents;
2. The date that the Dependent does not pay the premium due in full by the end of the grace period;
3. The date that the Dependent becomes covered under another group health plan (as an employee or otherwise), as long as such date is after the qualifying event. This may not apply if the Dependent has a pre-existing condition which is not covered under the new plan. Contact the Fund for additional information when your Dependent becomes covered under another group plan.
4. The date that the Dependent first becomes eligible for Medicare, as long as such date is after the qualifying event. This does not apply in situations where the qualifying event is the Employer's bankruptcy proceeding under the United States Bankruptcy Code.
5. The date that the applicable period of COBRA Continuation Coverage ends.

A Dependent's COBRA Continuation Coverage will not terminate solely because the Eligible Retiree's former Employer ceases to participate in the Fund. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/>. This program is offered by the federal government and the Fund Office has no role in, nor responsibility for, its administration.

Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage or the Plan, please contact the Fund Office or Empire. An Empire COBRA representative can be reached toll free at (877)233-7045.

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. Accordingly, the Fund will provide a Certificate of Creditable Coverage to you and your Dependent(s) within

a reasonable time after the occurrence of any of the following events:

1. loss of coverage under the Fund in the absence of COBRA Continuation Coverage;
2. loss of coverage under the Fund;
3. loss of COBRA Continuation Coverage;
4. upon written request within the first two (2) years of the loss of coverage under the Fund.

The Certificate of Creditable Coverage may be necessary to reduce any exclusion for pre-existing conditions that may apply to you or your Dependents under a new group health plan or health insurance policy and will indicate the period of coverage under this Fund and certain additional information that is required by law. The Certificate of Creditable Coverage will be sent to you or your Dependents by first class mail. To request a Certificate, write to the Fund Office at the following address:

Division 1181 A.T.U. — New York Welfare Fund
101-49 Woodhaven Boulevard
Ozone Park, NY 11416
718-845-5800

If you request a Certificate, the Fund will send it within a reasonable and prompt period of time.

SECTION 11 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Federal law has made several important changes to your ability to enroll children in the Fund. The Fund will provide coverage to your child if required to do so under the terms of a qualified medical child support order (referred to as a “QMCSO”). The Fund will provide coverage to a child under a QMCSO even if you do not have legal custody of the child, the child is not dependent on you for support, or the child does not reside with you, and regardless of any enrollment season restrictions that otherwise may exist for Dependent coverage. If the Fund receives a QMCSO and if you do not enroll the affected child, it will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You can request a copy of the Fund’s procedures for determining whether an order is a QMCSO without charge from the Fund Office.

The Fund will also provide Dependent coverage for a child that is placed for adoption with you regardless of whether the adoption is finalized. A child will be considered placed for adoption with you if you assume a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child’s placement with you will be considered terminated when you no longer have a legal obligation to support the child. You will be required to supply evidence to the Fund that a child for whom Dependent coverage is requested has actually been placed with you for adoption. Additionally, pre-existing medical conditions that would otherwise be excluded from coverage will not apply to a child that is adopted or placed for adoption with you.

SECTION 12 GENERAL CLAIMS PROCEDURES

A. For Pre-65 Retirees:

IF YOU NEED TO FILE A HOSPITAL OR MEDICAL CLAIM

Empire makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received out-of-network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	Provider files claim with Empire or local Blue Cross/Blue Shield plan*
MEDICAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire
AMBULANCE CHARGES	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire

* At some out-of-area and non-participating hospitals, you may have to pay the hospital’s bill. If this happens, include an original itemized hospital bill with your claim.

Send completed forms to:

Hospital Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional
Claims Department

Medical Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Department

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting www.empireblue.com.

Tips for Filing a Claim

- Visit www.empireblue.com to print out a claim form immediately or contact Member Services at 1-800-342-9816 to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer’s Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

Please remember that at either the time of admission to the hospital, or before receiving services from a non-hospital provider, please present both your Empire ID card.

B. For Post-65 Retirees

HOW TO CLAIM BENEFITS:

In-patient Care. At the time of admission to a Hospital, present both your Medicare and your Division 1181 A.T.U.-New York Welfare Fund Hospital Benefit I.D. cards.

Out-patient Care. Present both your Medicare I.D. card, if any, and your Division 1181 A.T.U.-New York Welfare Fund Medical Benefit I.D. cards.

TO FILE A CLAIM:

Most health care providers submit medical charges to the Fund Office on the universal HCFA 1500 form. If your provider does not use this form, you must request the necessary medical claim forms from the Fund Office. The provider must complete the appropriate part of the claim form, and you must complete and sign the Employee's Statement, and attach the provider's itemized statement of charges, if the information has not been noted on the claim form. If the patient has other insurance coverage, you must attach the Explanation of Benefits, or Medicare's Explanation of Benefits Statement, whichever is applicable. You should sign Item No. 12, "Authorization to Release Information," and Item No. 13, "Authorization to Pay," if you wish your benefits to be paid directly to the provider. The completed claim forms and all supporting documents should then be mailed or forwarded to the Fund Office.

C. Claims Filing Deadline

If you are a pre-65 Retiree, claims must be received by Empire no later than 12 months from the date in which services were rendered. For example, claim forms for services rendered on July 1, 2010 must be received no later than July 1, 2011. FILE YOUR CLAIM AS SOON AS POSSIBLE.

If you are a post-65 Retiree, claims must be received by the Fund Office no later than 12 months from the date the provider submits the claim to Medicare.

If you have any questions regarding the filing of your claim, contact the Fund Office at (718) 845-5800, Ext. 262.

**SECTION 13
CLAIM DENIALS**

I. GENERAL PROCEDURES

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. Please contact the Fund Office for a form to designate a representative. In the case of an Urgent Care claim, defined below, a health care professional with knowledge of your medical condition will be permitted to act as your representative. The Fund does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of Trustees nor the Fund will be responsible for paying any expenses that you might incur during the course of an appeal.

The Fund and its Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

For pre-65 Retirees, Empire is charged with the processing of hospital and medical claims under the Plan on the Fund's behalf, and Medco is charged with processing prescription drug claims. For post-65 Retirees, the Fund Office is responsible for processing all hospital and medical claims. Appeals for all benefits will be handled by the Fund. Please note that even though the foregoing section refers to the Fund, the aforementioned entities will be responsible for processing claims and appeals within the appropriate time limits set forth below. The Fund's procedures and time limits for processing medical claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Life Insurance benefits under the Fund are provided pursuant to an insurance contract between the Fund and Standard Life Insurance Company. For a description of the procedures that you must follow in order to submit a Life Insurance claim and the procedures you must follow in order to appeal the denial of a Life Insurance claim, please refer to your Standard Group Life Insurance Policy or contact Standard Life at 360 Hamilton Ave., Suite 210, White Plains, NY 10601-1871.

II. INITIAL CLAIM REVIEW

The length of time required to process your claim depends upon the type of claim.

Pre-Service Claims. A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the Fund's approval of the benefit before you receive the medical care. For example, a request for hospital admission for which pre-certification is required, as described in Section 4 of this Summary Plan Description, would be a pre-service claim.

If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five (5) days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

Urgent Care Claims. An Urgent Care claim is a pre-service claim that requires shortened time periods for making a determination where the longer time periods for making non-Urgent Care determinations (i) could seriously jeopardize your life or health or your ability to regain maximum function or (ii) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. It is important to note that the rules for an Urgent Care claim apply only when the Plan requires approval of the benefit *before* you receive the services; these rules do not apply

if approval is not required before health care is provided, for example in the case of an emergency.

If your Urgent Care claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. The Fund will notify you of the decision on your Urgent Care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than within seventy-two (72) hours after the claim is received by the Fund, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the Fund needs more information, the Fund will notify you of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Fund. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. The Fund will notify you of its decision as soon as possible, but not later than forty-eight (48) hours after the earlier of (i) the Fund's receipt of the specified information or (ii) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, which will be followed by a written notice of the same information within three (3) days of the oral notice.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will have to decide the claim based on the information it has available, and your claim may be denied.

Concurrent Care Claims. A Concurrent Care claim is a request for the Fund to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If you have been approved by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the Fund will notify you of the decision (whether approved or denied) within twenty-four (24) hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least twenty-four (24) hours before the end of the previously approved period of time or number of treatments.

Post-Service Claims. A post-service claim is any claim under the Plan that is not a pre-service claim. Typically, a post-service claim is a request for payment by the Fund after you have received the services.

If the Fund denies your post-service claim, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but not later than thirty (30) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund

expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information requested, the Fund will decide the claim based on the information it has available, and your claim may be denied.

For all Medical claims: If the Fund denies your claim, in whole or in part, the Fund will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, then this notice may be oral, followed in writing. The notice will provide (a) the specific reason or reasons for denial; (b) reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (d) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims; (e) a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

III. APPEAL PROCEDURES

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees. Your appeal must be in writing and must be sent to the Board of Trustees at the address above. (See page 38). An appeal of an Urgent Care claim (see above) may also be made by telephone by calling Empire at (866) 513-2473.

If your claim for medical benefits has been wholly or partially denied, you will have one hundred eighty (180) days from receipt of the denial notice to file an appeal with the Fund's Board of Trustees. The written appeal should be addressed to the Board of Trustees and must include: (a) your name and address; (b) the fact that you are appealing a benefits decision; (c) the basis of the appeal including all the facts regarding your claim as well as the reasons that you feel the denial was incorrect.

Pursuant to your right to appeal, you will have the right (a) to submit written comments, documents, records, and other information relating to your claim for benefits; and (b) upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a healthcare professional in the

appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of Trustees, through Empire, will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than seventy-two (72) hours after the Fund's receipt of your appeal. In the case of an appeal of a pre-service claim, the Board of Trustees will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

For appeals of all other claims, the Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within 5 days of the decision.

If the Board of Trustees has denied your appeal, the notice will provide (a) the specific reason or reasons for the denial; (b) references to specific Plan provisions on which the denial is based; (c) 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 for benefits; and (d) a statement of your right to bring an action under Section 502(a) of ERISA. In addition, the notice will state that (a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (b) if the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

If your claim is denied, in whole or in part, you are not required to appeal the decision. You have a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") on your claim for benefits. However, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement of your Summary Plan Description.

SECTION 14 SUBROGATION AND REIMBURSEMENT

Were you or your eligible dependent injured in a car accident or other accident for which someone else is liable? If so, that person (or his/her insurance) may be responsible for

paying your (or your eligible dependent's) Medical and Weekly Disability expenses, and these expenses would not be covered under the Fund.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay you (or your eligible dependent) benefits based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. The Fund advances benefits to you and your dependents only as a service to you. You must reimburse the Fund if you obtain any recovery from another person or entity.

You and/or your dependent are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

If you or your dependent receive any benefit payments from the Fund for any injury or sickness, and you or your dependent recover any amount from any third party or parties in connection with such injury or sickness, you or your dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your dependent's behalf in connection with such injury or sickness.

Also, if you or your dependent receive any benefit payments from the Fund for any injury or sickness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such injury or sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such injury or sickness in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the injury or sickness, and regardless of whether you and/or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's right of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the injury and sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery. The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is

due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for Fund expenses, fees, and costs.

Consistent with the Fund's rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the Fund for an injury or sickness that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by your or your dependent's attorney, if applicable. Alternatively, if you or your dependent or a representative of you or your dependent (including your attorney) fail or refuse to execute the required "Subrogation, Assignment of Rights, and Reimbursement Agreement" and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party. Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund. This means that if you file a claim and your Subrogation Agreement is not received promptly, the claim will be untimely and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be covered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section. The Fund's payment of benefits is secondary to PIP, medical payment, no-fault, and similar insurance.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office or Empire Blue Cross Blue Shield immediately. Where you or your eligible dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid,

the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your and your dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you and/or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you and/or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. By accepting benefits under the terms of this Plan, you and your dependents agree to waive any applicable statute of limitations defense available regarding the enforcement of any of the Fund's rights to reimbursement.

This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your injuries.

SECTION 15 RIGHT OF RECOVERY

If any incorrect payment is made by the Fund, the Fund has the right to recover any such amount from the Eligible Retiree or from the Dependent to or on whose behalf the payment was made or from the service provider that received the payment, as well as from any other person covered through the Eligible Retiree. Such amount may be deducted from any future benefit payment to which a person may be entitled from the Fund. If an incorrect payment is made to or on behalf of an Eligible Retiree or Dependent, the Eligible Retiree and the Dependent are both responsible for the overpayment and the Fund has the right to recover any overpayment from either or both individuals, or from any other person covered through the Eligible Retiree.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits

from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits. If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits overpaid by the Fund, you and/or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you and/or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. By accepting benefits under the terms of this Plan, you and your dependents agree to waive any applicable statute of limitations defense available regarding the enforcement of any of the Fund's rights to reimbursement.

The Fund reserves the right to retroactively rescind or cancel your coverage under the Plan if you or any of your Dependents engage in fraud and/or intentional misrepresentation of a material fact, or if you or your Employer fails to timely pay premiums or contributions to the Fund. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status, accepting benefits in excess of what is covered under the Plan or after you or your Dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having knowledge of all the eligibility terms of this Plan. In the event that the Fund has made benefits to you on your behalf in error as a result of any of the above events, you are required to reimburse the Fund for all benefits overpaid, pursuant to this Section.

**SECTION 16
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective Date of Notice April 14, 2003

The Division 1181 A.T.U. — New York Welfare Fund (the "Fund") is required to take reasonable steps to ensure the privacy of your personally identifiable health information in accordance with the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"). In addition, the Fund must inform you about:

1. The Fund's uses and disclosures of Protected Health Information ("PHI");
2. The Fund's duties with respect to your PHI;
3. Your rights with respect to your PHI;
4. Your right to file a complaint with the Fund and the Secretary of the U.S. Department of Health and Human Services;
5. The identity of the person to contact for additional information about the Fund's privacy practices.

PHI includes all individually identifiable health information that is transmitted or maintained by the Fund, or on behalf of the Fund, in connection with the Fund's

provision of medical, dental, vision and pharmacy benefits, regardless of whether the information is transmitted or maintained orally, on paper or through electronic medium (such as e-mail).

INFORMATION SUBJECT TO THIS NOTICE

The Fund provides not only health care benefits but other non-health care benefits, such as life insurance benefits. It is the intent of the Fund, as permitted by the privacy regulations issued under HIPAA, to limit the application of those regulations to health care components of the Fund's Plan of benefits ("Plan"). Thus, the benefits under the Plan subject to HIPAA Privacy regulations include all the health care components of the Plan, including all medical and hospital benefits but do not include the non-health care components.

USES AND DISCLOSURES OF PHI MADE WITHOUT YOUR CONSENT

The Fund uses PHI to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Fund may disclose your PHI to insurers, third party administrators, and health care providers for treatment, payment or other health care operations purposes. The Fund may also disclose your PHI to other third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases, your authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

Uses and Disclosures to the Fund Sponsor — The Fund may disclose your PHI to the Board of Trustees as the Fund's sponsor, to enable the Board of Trustees to administer the Fund. Such disclosures may be made without your authorization. The Fund's governing documents have been amended to reflect the Trustees' obligation to protect the privacy of your health information and the Board of Trustees has certified that it will protect any PHI it receives in accordance with federal law.

Uses and Disclosures to Business Associates — The Fund shares PHI with its "business associates," which are third parties that assist the Fund in its operations such as preferred provider networks and prescription benefit program managers. The Fund enters into agreements with its business associates so that the privacy of your health information will be protected by them. A business associate must have any agent or subcontractor to whom the business associate provides your PHI agree to the same restrictions and conditions that apply to the business associate. The Fund is permitted to disclose PHI to its business associates for treatment, payment and health care operations without your authorization as described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations — The Fund and its business associates will use and disclose PHI without your authorization for treatment, payment and health care operations as described below.

For Treatment — While the Fund does not anticipate making disclosures of PHI related to your health care treatment, if necessary, such disclosures may be made without your authorization. For example, the Fund may disclose the name of a treating specialist to your treating physician to assist your treating physician in obtaining records from the specialist.

For Payment — The Fund may use and disclose PHI so that your claims for health care treatment, services and supplies can be paid in accordance with the Fund’s plan of benefits. For example, the Fund may tell a doctor whether you are eligible for coverage or what portion of your medical bill will be paid by the Fund.

For Health Care Operations — The Fund may use and disclose PHI to enable it to operate efficiently and can include quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, conducting or arranging for medical review, legal services and auditing functions, business planning and general administrative activities. For example, the Fund may disclose PHI to its actuaries and accountants for benefit planning purposes.

Other Uses and Disclosures That May Be Made Without Your Authorization. In addition to the uses and disclosures of PHI described above for treatment, payment or health care operations as described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization.

Required by Law. PHI may be used or disclosed for judicial and administrative proceedings pursuant to court or administrative order, legal process and authority; to report information related to victims of abuse, neglect, or domestic violence, or to assist law enforcement officials in their law enforcement duties.

Health and Safety. PHI may be disclosed to avert a serious threat to the health or safety of you or any other person. PHI also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

Government Functions. PHI may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. PHI may also be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

Active Members of the Military and Veterans. PHI may be used or disclosed in order to comply with laws and regulations related to military service or veterans’ affairs.

Workers’ Compensation. PHI may be used or disclosed in order to comply with laws and regulations related to Workers’ Compensation benefits.

Research. Under certain circumstances, PHI may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

Organ, Eye and Tissue Donation. If you are an organ donor, your PHI may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

Treatment and Health Related Benefits Information. The Fund or its business associates may contact you to provide information about treatment alternatives or other health related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

Deceased Individuals. The PHI of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Emergency Situations. PHI may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

Others Involved In Your Care. Under limited circumstances, your PHI may be used or disclosed to a family member, close personal friend, or others whom the Fund has verified are directly involved in your care. For example, this may occur if you are seriously injured and unable to discuss your case with the Fund. Also, upon request, the Fund may advise a family member or close personal friend about (1) your general condition, (2) your location, such as “in the hospital,” or (3) your death. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

Personal Representatives. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those people who have Power of Attorney for adults.

USES AND DISCLOSURES OF PHI PURSUANT TO YOUR AUTHORIZATION

Uses and disclosures of your PHI **other than** those described above will be made only with your express written authorization. You may revoke your authorization at any time, provided you do so in writing. If you revoke a written authorization to use or disclose PHI, the Fund will not use or disclose your PHI, except to the extent that the Fund already relied on your authorization. Once your PHI has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your PHI may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

YOUR RIGHTS WITH RESPECT TO YOUR PHI — You have the following rights regarding your PHI that the Fund creates, collects and maintains.

Right to Inspect and Copy Health Information. You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your eligibility and coverage under the Fund’s plan of benefits as well as claims and billing records. To inspect or to obtain a copy of your health record, submit a written request to the Fund’s HIPAA Privacy Officer identified below. (See page 53). The Fund may charge a reasonable fee based on the cost for copying and mailing records associated with your request. In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. This denial will be provided in writing and will set forth the reasons for the denial and will describe how you may appeal the Fund’s decision.

Right to Request That Your Health Information Be Amended

You have the right to request that your PHI be amended if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed written request to the Fund’s HIPAA Privacy Officer identified below. The Fund may deny your request if it is not made in writing, if it does not provide a basis in support of the request, or if you have asked to amend information that (1) was not created by or

for the Fund, (2) is not part of the health information maintained by or for the Fund, (3) is not part of the health record information that you are permitted to inspect and copy, or (4) is accurate and complete. If the Fund denies your request, it will explain the basis for the denial in writing. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of PHI.

Right to an Accounting of Disclosures. You have the right to receive a written accounting of disclosures by the Fund of your PHI made during the six years prior to the date of your request. However, such accounting will not include disclosures made (1) for treatment, payment or health care operations, (2) to you or authorized by you, (3) prior to April 14, 2003, (4) that where otherwise permissible under law and the Fund's privacy practices, or (5) that constitute incidental disclosures. To request an accounting of disclosures, submit a written request to the Fund's HIPAA Privacy Officer identified below. If you request more than one accounting within a 12 month period, the Fund will charge a reasonable fee based on the cost for each subsequent accounting. The Fund will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions. You have the right to request that the Fund restrict the use and disclosure of your PHI. However, the Fund is not required to agree to your request for such restrictions, and the Fund may terminate a prior agreement to the restrictions you requested. To request restrictions on the use and disclosure of your PHI, submit a written request to the Fund's HIPAA Privacy Officer identified below. Your request must explain what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates any agreement with respect to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location. You have the right to request that your PHI be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your PHI at a specific location. To request communications by alternative means or at an alternative location, submit a written request to the Fund's HIPAA Privacy Officer identified below. (See page 53). Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain — You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the Fund's HIPAA Privacy Officer identified below. The Fund will not retaliate or discriminate against you and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund or with the Department of Health and Human Services.

Right to a Paper Copy of this Notice — You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Fund's HIPAA Privacy Officer identified below.

Contact Information — If you have any questions or concerns about the Fund’s privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund’s privacy practices or if you wish to exercise one of the rights described above with respect to your PHI, please contact:

HIPAA Privacy Officer
Division 1181 A.T.U.-New York Welfare Fund
101-49 Woodhaven Blvd
Ozone Park, NY 11416
(718)-845-5800

CHANGES IN THE FUND’S PRIVACY POLICIES

The Fund reserves the right to change its privacy practices and make the new practices effective for all PHI that it maintains, including PHI that it created or received prior to the effective date of the change and PHI it may receive in the future. If the Fund materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, by U.S. mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request.

SECTION 17

OTHER IMPORTANT INFORMATION

The following information is provided to you as required by ERISA:

Plan Name: Division 1181 A.T.U. — New York Welfare Fund

Employer Identification Number: 23-7255573

Plan Number: 503

Plan Year and Fiscal Year: January 1 to December 31

Type of Plan: The Plan is an employee welfare benefit plan with a plan of benefits providing Hospital Benefits, Major Medical Benefits, Death and Accidental Death and Dismemberment Benefits, New York State Weekly Disability Benefits, Optical Benefits, Dental Benefits and Prescription Drug Benefits to Active Employees and other miscellaneous benefits, as well as Hospital Benefits and limited Medical Benefits to Eligible Retirees.

Plan Sponsor: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Boulevard, Ozone Park, New York 11416, (718) 845-5800.

Plan Administrator: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Boulevard, Ozone Park, New York 11416, (718) 845-5800.

Agent for Service or Legal Process: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 101-49 Woodhaven Boulevard, Ozone Park, New York 11416. Process may be served on the Board of Trustees as Plan Administrator or upon any Trustee.

Source of Benefits: Benefits are provided on a self-funded basis through a jointly administered trust. The life insurance benefit is provided through a policy of insurance with Standard Life Insurance Company. This benefit is paid through the insurance contract and Standard Life Insurance Company provides claims processing services for these benefits.

Source of Contributions: Benefits under the Plan are funded by the assets of the trust, which are funded from contributions from employers that are signatories to collective bargaining agreements with the Union. Contributions are also received from the Union, Division 1181 A.T.U. — New York Welfare Fund, Division 1181 A.T.U. — New York Employees Pension Fund and Division 1181-1061 A.T.U. — Federal Credit Union on behalf of their employees. Upon written request, a complete list of the participating employers and employee organizations sponsoring the Plan may be obtained from the Plan Administrator.

Funding Medium: The assets of the Fund are held in trust administered by the Board of Trustees. The assets of the Fund are used to pay benefits and administrative expenses of the Fund.

Collective Bargaining Agreements: The Fund is maintained pursuant to collective bargaining agreements between the Union and various employers. Upon written request, you may obtain from the Plan Administrator a copy of the collective bargaining agreement under which you were employed. Copies of collective bargaining agreements may be examined at the Fund Office.

Type of Administration: The Board of Trustees is the Plan Administrator. The Board of Trustees employs Empire Blue Cross Blue Shield to provide claims processing and other related administrative services for pre-65 Retirees. The Board of Trustees also employs employees to handle other day-to-day administrative management services.

List of Trustees: The members of the Board of Trustees of the Division 1181 A.T.U.-New York Welfare Fund are as follows:

UNION TRUSTEES

Michael Cordiello, Chairman
Division 1181 A.T.U.
101-49 Woodhaven Boulevard
Ozone Park, NY 11416

Thomas Jemmott
Division 1181 A.T.U.
101-49 Woodhaven Boulevard
Ozone Park, NY 11416

Jean-Claude Calixte
Division 1181 A.T.U.
101-49 Woodhaven Boulevard
Ozone Park, NY 11416

James Hedge
Division 1181 A.T.U.
101-49 Woodhaven Boulevard
Ozone Park, NY 11416

EMPLOYER TRUSTEES

Stanley Brettschneider
G.T.J. Co., Inc.
444 Merrick Road – Suite 370
Lynbrook, N.Y 11563

Domenic Gatto
Atlantic Express
7 North Street
Staten Island, N.Y 10302

Andrew Brettschneider
Varsity Bus Co.
626 Wortman Avenue
Brooklyn, N.Y 11208

Neil Strahl, Secretary
Pioneer Transportation
2890 Arthur Kill Road
Staten Island, N.Y 10309

STATEMENT OF ERISA RIGHTS

As an Eligible Retiree in the Division 1181 A.T.U. — New York Welfare Fund, you are entitled to rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at Fund Office all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary Plan description upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Eligible Retiree with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue group health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There can be a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The Plan does not give you any right to continue in Employment. However, 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110.00 a day until you receive the materials, unless the materials were not sent because of

reasons beyond the control of the 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 medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay the 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 if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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