

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



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

SUMMARY PLAN DESCRIPTION

Revised July 1, 2016

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

20 NORTH CENTRAL AVENUE
VALLEY STREAM, NEW YORK 11580
(718) 845-5800

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GENERAL INTRODUCTION

This document is the Plan of benefits for the Division 1181 A.T.U. — New York Welfare Fund. It also is the “Summary Plan Description” or “SPD.” The provisions of this document are subject to amendment and interpretation by the Board of Trustees and to the rules and 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. Any decision made by the Board of Trustees in good faith is binding upon Employers, Employees, Participants, Dependents, 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, you should get in touch with the Fund Office or a customer service representative at Empire Blue Cross Blue Shield (“Empire”). The Fund Office address is Division 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580. Telephone: (718) 845-5800. The Fund Office hours are 8:00 a.m. to 4:00 p.m. Empire’s address is Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, N.Y., 10008. Telephone: (866) 513-2473. Empire’s hours are 9:00am to 5:00pm EST.

The benefits described reflect the benefits available to you, 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.**

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 Participant 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 by 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.

Notice – Cancellation of Coverage. 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 or intentional misrepresentation of a material fact, or if you or your Employer fail(s) 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(s) 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 Section 21 of this SPD. **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 your Employer, your Union, or anyone else.** It is extremely important that you keep the Fund Office informed of any change in address or desired changes in Dependent(s) and/or beneficiary(ies). This is your obligation and you could lose benefits if you fail to do so. The importance of having a current, correct address on file with 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 Plan ("Summary Plan Description"). Las provisiones de este documento están sujetas a enmendar e 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 interpretaran y aplicaran en situaciones no específicamente consignadas en este documento. En caso de conflicto entre los términos de este resumen y los términos del Plan, los términos del Plan dominaran.

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 Empire. La dirección es Division 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580. Teléfono: (718) 845-5800. La dirección es, Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. (866) 513-2473 (9:00am – 5:00pm EST). Teléfono: (866) 513-2473 (9:00am – 5:00pm EST)

Por favor quisiéramos recordarle que solamente el Fondo puede verificar los derechos y beneficios que le cubre el Plan a usted. No dependa en ningún tipo de información sobre su Plan hecho por su Empleador, Agente Shop Steward, o Agente de Unión.

Es de suma importancia que usted mantenga la oficina del fondo informada de cualquier cambio de dirección, estado civil, o beneficiaros. Esta es su obligación y usted podría perder sus beneficios si usted no cumple con su obligación. La importancia de una dirección corriente y correcta en los expedientes de la oficina del Fondo no puede ser pasada por alto. Es la **UNICA** manera en la cual fideicomisarios pueden mantenerse en contacto con usted, en respecto a cualquier cambio en el Plan y otros acontecimientos que afecten sus intereses en el Plan.

INTRODUKSYON JÉNÉRAL

Dokiman sa-a gen dé bagay ladan plan dokinan-an ak rézime plan 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 egzijé-l. Board of Trustees gen dwa intèprété tout sa kinan dokiman, é kapab apliké-l nan yon sitiyasyon ki pa nan dokiman sa-a.

Dokiman sila gen yon rézime an anglè ki gen tout dwa akavantaj nan lokal Divizion 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. Divizion 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580. Tel: (718) 845-5800 es Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. (866) 513-2473 (9:00am – 5:00pm EST). Tel: (866) 513-2473 (9:00am – 5:00pm EST)

Bénéfis sa ké yo présenté-la jénéralman sé you bénéfis ki la pou-ou, men yo kapab révizé-l dé tanzantan. Li réyelman inpotan pou gadé kouvèti ké-ou genyen ak Fund Office-la avan ké ou kouri al fè depans san ké ou pa si, si-ou genyen kouvèti pou-ou ak dépendan ké-ou mètè. Tanpri souplé pa jam blié sé sel Fund Office-la ki kapab gadé si-ou gen kouvèti li inpotan, pou nou pa gadé sou sa moun'n ap di, kit sé té employé, shop-steward oubyen inion délégé.

Li reyelman inpòtan pou-w kinbé kontak ak Fund Office-la pou ninpòt adres oubyen depandan ké-ou chanjé, se dwa-ou. San sa ou kap pèdi tout bénéfis si ké ou pa fè sa. Moin pa ka di-ou inpotans ké sa gen ladan, pou Fund Office-la gen korèk adres-ou se sel jan pou Trustees-la kimbé kontak ak oumen sou kesyon chanjé plan ak lot bagay ki kap afekté sou plan sa-a.

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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 are capitalized and have the following meanings:

Active means actually performing each of the material duties of your occupation and being at work at the usual and customary place of business of an Employer.

Allowable Charge means the lowest of: (1) the amount listed in the Fund's Schedule of Allowances for a given procedure; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the charge that the Fund would pay under an agreement with a Preferred Provider organization to provide services to Covered Persons; or (4) the health care provider's actual charge (except for in-network hospital claims).

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

COBRA means the Consolidated Omnibus Reconciliation Act of 1985.

Covered Person means a Participant and his or her Dependent(s).

Dentist means a licensed doctor of dentistry acting within the scope of his or her license.

Dependent means:

A. In General. Dependent means the following: (1) your legal 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 he or she becomes age 26; or (3) your foster child from birth to the end of the calendar year in which he or she becomes 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 a Dependent, 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").

B. Student Coverage for Foster Children. Your foster child who is a full-time student enrolled for at least 12 credits per semester (9 credits per trimester) in an accredited school may be your Dependent under the Plan until the end of the calendar year in which he or she becomes 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 foster 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.

C. Dependent Children 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 26 and is dependent upon you for support and maintenance. In such circumstances, you must submit a comprehensive medical report including the 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.

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

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

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

Experimental means 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.

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

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 or dental 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 or dental 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.

Open Enrollment means the period from October 1st to October 31st of each year in which a Participant can revoke his or her waiver of coverage under the Plan.

Ophthalmologist means a licensed doctor acting within the scope of his or her license who is a medical specialist in eye diseases and refractive errors.

Optician means a licensed professional acting within the scope of his or her license who grinds lenses to be inserted in frames for remedying defects of vision in concurrence with the prescriptions of an Optometrist or Ophthalmologist.

Optometrist means a licensed professional acting within the scope of his or her license who performs eyesight test examinations for the purpose of prescribing eyeglasses.

Participant means an Employee in Active Employment who meets the eligibility requirements of Section 2 of the SPD. Generally, you will continue to be considered a Participant:

- A. While you are receiving Weekly Disability benefits from the Fund (see page 25);
- B. While you have a Disability and are entitled to an extension of coverage for up to 52 weeks under Section 2(C) and (D) (see pages 8-9);
- C. While you are receiving Workers' Compensation benefits, and your Employer is obligated to contribute to the Fund on your behalf;
- D. While you are on an approved Leave of Absence (see page 9) or Leave under the Family and Medical Leave Act of 1993 (see page 53) and you or your Employer are/ is obligated to contribute to the Fund on your behalf).

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.

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 admitted 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.

Spouse means an individual to whom you are legally married, including a same-sex spouse.

Successive Periods of Confinement means two or more periods of Hospital confinement or surgical procedures due to the same or related causes that are considered one confinement or procedure because they are not 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.

Union Representative means Union members serving as officers of the Union, Union employees or employees of Division 1181 A.T.U. — Federal Credit Union.

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

SECTION 2 ELIGIBILITY FOR BENEFITS

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

A. ELIGIBILITY OF ACTIVE EMPLOYEES.

You become eligible for benefits as an Employee on the first day of the month following satisfaction of your initial waiting period under the applicable collective bargaining agreement ("CBA") (see below), provided that you have not waived coverage under the opt-out provisions of the applicable CBA. See Section 3(F) of this SPD as to when you become eligible for benefits after you cease being an Employee and are then rehired.

Effective January 1, 2014, once you start working in Employment, your coverage will commence on the first of the month following the earlier of (1) the completion of your initial waiting period in Employment, under the applicable CBA or (2) the 60th day after you complete 1200 hours of service.

Employees must make a weekly contribution to the Fund for coverage. This contribution is made by a pre-tax deduction from your wages through your Employer's cafeteria plan. The Employer is responsible for timely submitting this payment to the Fund on your behalf.

However, if you receive Fund coverage for a period during which you are not receiving a paycheck (i.e., while out on disability leave), there are different options available to you on how to pay weekly contributions while you are on leave. Please contact the Fund Office to discuss these options.

To receive benefits, you must complete an enrollment card at the Fund Office. You should bring copies of your marriage certificate, and birth certificates or adoption papers for each family member you wish to enroll as a Dependent with you to the Fund Office when you complete the enrollment card. **Only Dependents listed on your enrollment card are entitled to coverage.** See the Definition section and Section 2(B) below on who may be a Dependent. Enrollment cards also will be provided to custodial parents who are not Participants for enrollment of Dependents pursuant to a Qualified Medical Child Support Order. See Section 16, page 51.

IMPORTANT: NO BENEFITS WILL BE PAID UNTIL YOUR COMPLETED ENROLLMENT CARD IS RECEIVED AT THE FUND OFFICE.

B. ELIGIBILITY OF DEPENDENTS.

1. First Hired in the Industry Prior to May 20, 2010

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 Dependent child or Spouse to your enrollment card.** Generally, you may add or remove a Dependent from enrollment at any time.

2. First Hired in the Industry on or After May 20, 2010

If you were first hired by an Employer on or after May 20, 2010, you will not receive employer-paid Dependent coverage until you have met the requirements for such coverage under your applicable CBA. However, once you are eligible for self-only coverage, you can enroll your Dependents in Fund coverage by paying for the difference in total cost between single coverage and family coverage with a pre-tax wage deduction from your paycheck. Prior to commencing Fund coverage, the Fund will provide you with a form allowing you to elect Dependent coverage, which you must complete and return within 30 days from the date it is mailed to you. If you do not complete and return this form within 30 days from the date it is mailed to you, you will not be allowed to elect coverage for your Dependents until the next Open Enrollment period, occurring October 1st – October 31st of each year, with coverage effective November 1st.

As described in Section 2(E), there are certain “Qualifying Events”, such as getting married and having a child, which would allow you to elect coverage for your Dependents outside of the Open Enrollment period. You must notify the Fund Office and your Employer within 30 days of experiencing a “Qualifying Event” and complete any paperwork requested by your Employer and/or the Fund Office to establish that this event has occurred. If this is done, you can pay for the cost of Dependent coverage by a pre-tax wage deduction from your paycheck. If you incur a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as described in Section 2(F), and this event is not a “Qualifying Event” under your Employer’s cafeteria plan, you can still choose Dependent coverage and pay for the cost on an after-tax basis. For more questions about this process, please contact the Fund Office.

If you were working for an Employer prior to May 20, 2010 that would have been covered by the CBA, but it was prior to the date the Employer commenced participating in this Fund, your Dependents are eligible for Employer-paid Dependent coverage at the same time as you are eligible for coverage, provided that you had coverage for your Dependents prior to May 20, 2010 under your Employer's prior health plan. If you were only enrolled in single coverage prior to your Employer's participation in this Fund, your Dependents will not be eligible for employer-paid Dependent coverage until you satisfy applicable waiting period under the collective bargaining agreement for such coverage, measured from the date you started working in Employment.

3. First Hired On or After January 1, 2013

If you were first hired by an Employer on or after January 1, 2013 (or are treated as a new Employee under the CBA after terminating Employment with the Employer and being rehired on or after January 1, 2013), you may not be eligible for employer-paid Dependent coverage under the terms of your CBA. However, once you are eligible for self-only coverage, you will be able to enroll your Dependents in Fund coverage by paying the difference between single and family coverage with a pre-tax wage deduction from your paycheck, using the rules in Section 2(B)(2) above.

4. General Enrollment Procedures

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 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.

To add or remove a Dependent, in addition to the procedures that are described above, you also 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 (1) proof of marriage, birth, adoption, or foster care placement, to add a Spouse or child as a Dependent, (2) proof of disability to extend a child's coverage after age 26, (3) proof of student status to extend a foster child's coverage after age 19 or (4) proof of divorce, death or end of dependency to remove a Dependent.

C. EXTENSION OF FUND COVERAGE AFTER NEW EMPLOYEE DISABILITY OR NO-FAULT COVERED ACCIDENT.

If you are covered under the Plan for less than one year and experience a Disability or if your Disability arises from an accident covered by No-Fault insurance, you are entitled to a 26-week period of Weekly Disability benefits. See Section 7 on page 25. However, if your Disability continues after this 26-week period, you will continue to be entitled to all other benefits provided by the Fund for a total of 52 weeks from the date Weekly Disability benefits begin (provided that you continue to be Disabled)

D. EXTENSION OF FUND COVERAGE AS A RESULT OF RECEIVING DISABILITY BENEFITS FROM WORKERS' COMPENSATION BOARD SPECIAL FUND FOR DISABILITY BENEFITS.

See Section 7, page 25.

E. WAIVER OF FUND COVERAGE.

Your collective bargaining agreement may allow you to elect to waive Fund coverage, provided certain conditions are met. Generally, if you waive Fund coverage, you and your Dependents will not be eligible for any benefits from the Fund. However, even if you waive coverage, the CBA between your Employer and the Union might require you to receive Weekly Disability benefits and/or life insurance benefits from the Fund, assuming your Employer contributes to the Fund for such benefits. Please contact your Employer for more details.

Waivers generally are irrevocable and cannot be changed until the next Open Enrollment period in October. However, certain events, such as getting married or having a child, may allow you to enroll before the Open Enrollment period. These events are called "Qualifying Events" and are defined under your Employer's cafeteria plan. In addition, you may have special enrollment rights under federal law, as described in the next paragraph ("HIPAA Special Enrollment Period").

F. HIPAA SPECIAL ENROLLMENT PERIOD.

If you decline enrollment for yourself or your Dependent(s) (including your Spouse) under the Plan because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). If that other coverage is COBRA coverage, you will have the right to enroll yourself after that COBRA coverage is exhausted. However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To obtain special enrollment or for more information, contact the Fund Office.

You may be able to enroll yourself and your Dependent(s) in this Plan if you or your Dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"). However, to do so, you must request enrollment within 60 days of the date that CHIP or Medicaid assistance is terminated for you or your Dependent(s). In addition, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. However, you must request enrollment within 60 days of the date you or your Dependents are determined to be eligible for the premium assistance through Medicaid or CHIP.

SECTION 3 TERMINATION OF COVERAGE

A. GENERAL RULE.

Your coverage for benefits terminates on the last day of the month for which your Employer is obligated to contribute to the Fund on your behalf. *See* Section 15 for information regarding your right to COBRA Continuation Coverage.

Coverage for Dependents terminates on the earlier of (1) the date your coverage terminates or (2) the date the individual no longer meets the definition of Dependent (for example, the date you and your Spouse are legally separated, or when a Dependent child attains age 26).

B. TERMINATION AT THE END OF DISABILITY.

If you are unable to return to Employment after receiving the maximum number of weeks of Weekly Disability benefits under the Plan, (See Section 7), coverage terminates on the last day of the month following the last date you received Weekly Disability benefits, except as provided under the special rules described in Section 2(C) and (D) above.

Where coverage terminates, you and your Dependents may be entitled to elect COBRA Continuation Coverage from the date your coverage terminates. The Fund will provide you with information regarding your right to COBRA Continuation Coverage if you are eligible. You are eligible for retiree benefits if (1) you are employed at the time of your termination of Employment by any Employer that contributes to this Fund, and (2) you are eligible to receive a pension benefit from the Division 1181 A.T.U – New York Employees Pension Fund or the Command- Local 1181 Pension Fund at the time of your termination of Employment based on 10 years of credit service under either pension fund. Generally, you have 60 days from the date of your termination to elect retiree health (or, if you elect COBRA, from the date your COBRA coverage ends). For more details, please contact the Fund Office.

C. TERMINATION OF BENEFITS AS A RESULT OF A WORK-RELATED ILLNESS OR INJURY.

If you receive Workers' Compensation insurance, coverage will continue as long as your Employer is obligated to contribute to the Fund on your behalf under the collective bargaining agreement. If, after receiving Fund coverage while on Workers' Compensation insurance for the maximum period, you are still unable to return to work, coverage terminates. In such circumstances, you may be entitled to elect COBRA Continuation Coverage from the date coverage terminates.

D. BENEFITS PENDING OUTCOME OF A HEARING RELATED TO EMPLOYMENT.

If you are terminated from Employment, you will be covered under the Plan until the end of the month following the last day you worked. If you are reinstated as a result of an arbitration, coverage will be reinstated as of the first of the month in which you are reinstated to your job. If there is a back-pay award, coverage will be reinstated retroactively for the full period of the back-pay award, provided back contributions are awarded. For any interim period, Continuation Coverage under COBRA may be elected. (See Section 15.)

E. BENEFITS DURING A PARTICIPANT'S APPROVED LEAVE OF ABSENCE.

If you are on an approved leave of absence (up to a 60 day maximum), if you or your Employer contribute to the Fund for the period of the leave, you will remain covered for the period of the leave. Coverage during FMLA leave is discussed in Section 18 of this SPD.

F. TERMINATION FROM ONE EMPLOYER AND RE-EMPLOYMENT BY ANOTHER EMPLOYER.

If you voluntarily resign from Employment with an Employer, your coverage terminates on the last day of the month in which you resign. If you are rehired after resigning, you may have to satisfy a new waiting period upon re-Employment under your CBA before coverage will commence again, to the extent permitted by law.

If your Employment terminates because you are either laid off or suspended, your coverage also will terminate on the last day of the month in which you are laid off or suspended. However, if you are rehired in Employment with an Employer at some later date after you have been laid off, or your suspension expires, your coverage will immediately commence again. But, if your suspension eventually leads to a termination and then you are later rehired, you may have to satisfy a new waiting period under the CBA before coverage commences, to the extent permitted by law. Please contact the Fund Office for details.

G. CERTIFICATE OF CREDITABLE COVERAGE

In certain circumstances, federal law requires that the Fund provide you and your Dependent(s) with evidence of your coverage under the Fund for use as proof of prior coverage when beginning coverage under another health plan.

After December 31, 2014, because of the elimination of preexisting condition exclusionary periods, you will no longer need the Fund to issue a Certificate of Creditable Coverage.

SECTION 4 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 work-related Sickness or Injury that is compensable under Workers' Compensation laws. If Workers' Compensation benefits are denied, the procedures on pages 28-29 apply to determine eligibility for benefits. (If you fail to file a claim under Workers' Compensation, no Plan benefits are paid including Weekly Disability benefits.)
- B. 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, for example, (1) if you or your Dependent(s) 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.
- C. Charges in connection with a Sickness or Injury that was deliberately self-inflicted, including any suicide attempts or threats.
- D. 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.
- E. Charges for any Sickness or Injury resulting directly or indirectly from your intoxication due to a drug, narcotic or any other intoxicant.
- F. Services that are not Medically Necessary.

- G. 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.
- H. (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 Dependent is not required to pay, or (4) for which a claim is not filed within the deadline specified in Section 19.
- I. Charges paid for by any other person or entity.
- J. 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.
- K. Charges for any services rendered by an immediate family member.
- L. Charges for Experimental or obsolete procedures or drugs.
- M. Charges for services if you or your Dependent were not eligible for benefits at the time the claim was incurred.
- N. Charges for services if you or your Dependent failed to submit required evidence to support the claim.
- O. Charges for services if you or your Dependent made material misstatements in connection with eligibility or the claim.
- P. Charges for services if you or your Dependent omitted facts or material statements as to other coverage available to you.
- Q. Charges for services provided to you or your 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 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 20.

SECTION 5 HOSPITAL BENEFITS

Through its arrangement with Empire, the Fund has made available to 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 by using this network.

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.

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

A. IN-PATIENT SERVICES.

1. Room and Board. The Fund will cover up to 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, if there are fewer than 90 days between admissions. If there are 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 90 day period of separation between hospitalizations before another period of hospitalization will be covered.

In the event you or your 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 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 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 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 a Participant or a Participant's Spouse. Except to the extent required by law, Maternity benefits are not payable for the pregnancy of a Dependent child.

Hospital benefits will be provided for Hospital confinements arising from any pregnancy related condition, whether or not pregnancy is terminated. Additionally, Hospital benefits for routine nursery care of the newborn child or newly-born child adopted or placed for adoption with a Participant or a Dependent Spouse are provided during the mother's covered Hospital stay.

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. 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.

6. Copayment for Non-Empire Facility.

There is a \$500 copayment for all elective admissions and ambulatory procedures performed in a facility not in Empire's network (a "non-Preferred Provider"), unless it is the only facility performing the procedure. In the event that both parents of a Dependent child are Participants and the Dependent child has such procedures performed at a non-Preferred Provider, there will be only one copayment.

B. OUT-PATIENT SERVICES.

Hospital benefits are provided in the event you or your Dependent is not admitted as a patient but receives care in a Hospital emergency room or operating room. There is a \$100 copayment for in-network emergency room services, which will be waived unless you are admitted to the Hospital. If you go to an urgent care facility to be treated, your copayment will be \$25. The following out-patient services are covered:

1. Emergency Treatment and/or Ambulatory Surgery.

- a. Emergency first aid during the first visit for treatment of an accidental Injury;
- b. Emergency care during the first visit for treatment after 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.

If you receive emergency room services in a Hospital that is a non-Preferred Provider, the Fund will pay the greater of (a) the Allowable Charge, or (b) the amount that would have been paid by Medicare for these services. As with non-Preferred Providers, you may be responsible for the difference between whatever the Fund pays and the Hospital's original charges.

2. Presurgical Testing.

- a. Hospital benefits are provided for diagnostic tests when they are prescribed by your Physician as preliminaries to scheduled surgery, are given within 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 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.

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.

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 medication 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 Medically Necessary care.

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 begin 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 40 home care visits per calendar year.

D. SPECIAL CONDITIONS.

1. Mental or Nervous Disorders.

Hospital benefits for mental or nervous disorders are available for up to 120 days during a single hospitalization, or during several separate hospitalizations, if there are fewer than 90 days between Hospital admissions.

Mental health benefits provided under this Plan are treated the same as any medical/surgical benefit provided under this Plan, to the extent required by law.

Hospital benefits for mental or nervous disorders are not covered where the cause of the hospitalization is the current use of illegal narcotics or misuse of legal drugs.

2. Dialysis for Kidney Failure.

Hospital benefits are provided for hemodialysis or peritoneal dialysis while you or your Dependent is registered in-patient at 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 the 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.

E. HOSPICE CARE.

You and your 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 state law 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 6 months or less.

Covered hospice services include:

1. In-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 that are considered approved under the U.S. Pharmacopoeia and/or National Formulary (but are not covered when the drugs or medications are Experimental);
 - 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.

F. WORLDWIDE PROTECTION.

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

G. 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, unless Medically Necessary.

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.

H. 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 their 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.

I. LARGE CLAIM SETTLEMENT PROGRAM.

The Board has 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 not covered by the Plan. Please contact the Fund Office for more details on this program if all or part of your claim is not covered by the Plan.

J. DENIAL OR LOSS OF BENEFITS.

In addition to the exclusions applicable to all forms of benefits under the Plan (see page 12-13), 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 under 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 under Major Medical benefits);

K. HOW TO CLAIM HOSPITAL BENEFITS.

You should present your Empire BlueCross BlueShield 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 payments for any personal items, T.V. rental or, for a private room (i.e. 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.

SECTION 6 MAJOR MEDICAL BENEFITS

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

- The Fund has made available to you and your Dependents a network of preferred providers with Empire BlueCross/Blue Shield. With this network 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, you only pay the copayment, if any, to receive treatment for services covered by the Plan. Pre-certification is not required for office visits.
- If you do use a non-Preferred Provider for your Major Medical benefit, the Fund only will pay the Allowable Charge, which generally means 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. You will be responsible for the unpaid balance. Since Empire negotiates lower fees with the providers in its network, you likely will have to pay much more of the bill if you use a provider that is not part of the Empire network.

A. THE EMPIRE NETWORK.

The Fund's contract with Empire makes Empire's network of Physicians and laboratories available to you and your Dependents. Using Physicians that are part of the network saves you and the Fund money. With the network, 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 copayment is \$25 for each office visit with a primary care physician and \$40 for a specialist. However, if Limited Covered Medical Expenses are used (*See* Section 6, page 22), you may be responsible for paying the provider the difference between what the Fund pays 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 Empire's website for the nearest Preferred Provider in the network. The directory lists Physicians according to location and type of practice. A paper copy of Empire's network of Preferred Providers is available, free of charge, upon request.
2. Select a Physician, verify that he or she is participating in the network, and schedule an appointment.
3. For visits in either the home or office, show your Empire ID Card and pay the \$25 or \$40 copayment. There is also a \$25 copayment for in-network urgent care visits.
4. The Fund's contract with Empire covers certain preferred labs for diagnostic services. Show your Empire ID Card. There is a \$25 copayment. Using a lab facility within Empire's network can save you money because those facilities will accept payment by the Fund as full payment. Empire's online 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. SURGICAL PROCEDURES.

If you or your Dependents undergo 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. Since Empire negotiates lower fees with the providers in its network, you likely will have to pay much more of the bill if you use a non-Preferred Provider. 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.

C. 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. Since Empire negotiates lower fees with the providers in its network, you likely will have to pay much more of the bill if you use a non-Preferred Provider, except as provided in item 6 below.

The following services and supplies are covered 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 Fund's Allowable Charge only 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 tests, including x-rays that you receive as part of an annual physical you must have to work in Employment;
 - b. Computerized Axial Tomography ("CAT scan"), 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 taking and interpreting 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 is allowed up to a maximum 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 an 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. Air ambulances are covered. However, if Fund determines that the conditions for requiring air ambulance transport have not been met, but the Participant's condition did require transportation via a land ambulance, reimbursement for an air ambulance will be limited to the amount the Fund would have paid for a land ambulance. Ambulettes are not covered.
9. Charges by a Dentist for treatment of natural teeth due to accident. If a Participant receives treatment to repair sound and natural teeth because of an accident or injury, he or she must complete the treatment within 12 months of the accident or injury for the service to be covered. Otherwise, Major Medical benefits do not cover dental treatment (though such services may be covered under Dental benefits, *See* Section 8.)
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.
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 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 the various providers listed in Section 6(G) of this SPD.
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 treatment of mental and nervous disorders performed by a psychiatrist, psychologist or certified social worker. In-patient Physician charges are covered on the same terms as charges for any other Illness.

D. WELL CHILD CARE.

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

E. PREVENTIVE CARE SERVICES.

As required by law, the Fund covers a number of preventive care services without any Plan cost-sharing for you and your Dependents, such as physical exams, screenings, tests, vaccines, and other preventive services that are on the following recommendation lists after the services have been listed for at least one year prior to the current Plan Year:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B
- Recommended immunizations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- Preventive care and screenings provided for in the Health Resources and Services Administration comprehensive guidelines

To the extent a recommended service is provided as part of a regular office visit with your provider, the copayment for office visits still applies. However, you will not be responsible for any copayments or coinsurance for the above preventive services if required by law.

For example, vaccines to treat Human Papillomavirus (HPV), such as Gardasil, are included in the recommended lists. Therefore, there will be no cost-sharing requirement on each Gardasil vaccine, but the copayment for an office visit will apply if the vaccine is part of a regular office visit. These recommended lists also include age, frequency, setting and other limitations that may affect your ability to receive coverage for the service. If you have questions about whether a particular exam, screening, test or vaccine is covered, please contact Empire at 1 (866) 513-2473.

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

F. LIMITED COVERED MEDICAL EXPENSES: (PER COVERED PERSON).

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

The following charges are covered as Limited Covered Medical Expenses to the extent described below. Annual dollar and visit limits apply whether you use a Preferred or non-Preferred Provider. 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 an in-network Chiropractor, the Fund will not pay for additional visits to a Chiropractor that is a non-Preferred Provider.

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 X-rays.

2. Charges in connection with routine dermatology treatment will be paid up to a \$550 maximum per calendar year.
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 treatment that arises from diabetes;
 - b. Orthotics;
 - c. Casting, fabrication, and dispensing of orthotics;
 - d. Dispensing of surgical shoes. Jobst stockings are covered up to 10 pairs per year;
 - e. Surgical trays and sterile packs;
 - f. Out-patient operating room fees;
 - g. Fees for surgical assistant;
 - h. Post-operative X-rays and serial X-rays during surgery (such services may be covered as an ambulatory surgery, see page 14);
 - i. Injection of local anesthetic (such services may be covered as an ambulatory surgery, see page 14);
 - 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 or a Dentist will be paid up to \$5,000 maximum per lifetime;
6. Charges for Sclerosing and/or Ligation of Veins will be paid as follows:
 - a. unilateral — maximum payment of \$1,680 per lifetime;

- b. bilateral — maximum payment of \$1,881 per lifetime.
- 7. Charges for prosthetic wigs and toupees, subject to a \$350 maximum every 3 years.
- 8. Charges for at least 2 tobacco cessation attempts each year, which includes coverage for eight tobacco counseling sessions of 10 minutes in length each (including telephone counseling, group counseling, and individual counseling) without prior authorization.

G. DIABETIC PROGRAM.

Edge Park provides a diabetic program for Fund Participants, which features the FreeStyle Monitor 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. It also requires a much smaller drop of blood. Edge Park 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, or to speak with an Edge Park representative, call (800) 321-0591, Monday through Friday during the hours of 8:00AM and 9:00PM, and Saturday during the hours of 9:00AM and 3:00PM.

Disetronic Medical Systems provides the Accucheck Monitor that can test your blood sugar on your arm. This too will be free of charge along with the diabetic supplies, excluding insulin. For a brochure describing the monitor and strips, or to speak with a Disetronic representative, call (800) 280-7801, Monday through Friday during the hours of 8:00AM and 8:00PM.

There are two other providers, Animas Diabetes Care and Minimed Distribution, that do not have glucose monitors, but do provide carry pumps and other diabetic supplies, excluding insulin. Animas can be reached at (610) 644-8990, Monday through Friday during the hours of 8:00AM and 8:00PM, and Minimed can be reached at (800) 933-3322, Monday through Friday during the hours of 8:00AM and 6:00PM.

H. DENIAL OR LOSS OF BENEFITS.

In addition to the exclusions applicable to all forms of benefits under the Plan (Section 4), Major Medical benefits will not be paid for the following:

- 1. In-patient or out-patient facility charges (may be covered under Hospital benefits, *See* Section 5).
- 2. Charges for dental work or treatment, except biopsies (may be covered under Dental Benefits, *See* Section 8).
- 3. 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 (may be covered under Optical Benefits, *See* Section 10).
- 4. Charges in connection with organ transplants if the procedure has not been approved by the Fund.
- 5. Charges for testing and treatment of infertility, for the promotion of conception, for artificial insemination, in-vitro fertilization, gamete intra fallopian transfer, or

similar or related procedures, or for reversal of voluntary sterilization or restoration of fertility.

6. Charges for injections, except for those (1) allowed in connection with well child Care(See Section 6(D)), (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 an immunosuppressed condition. This exclusion for injections does not affect the preventive services covered under Section 6(E).
7. Charges for vitamin therapy, food supplements, or services of dieticians.
8. Charges for Glucometer, Dextrometer, Tens Unit, and inhalation therapy in office.
9. Charges for Thermogram.
10. Charges for surgical appliances that are stock items and not made to order, such as braces, elastic supports and cervical collars.
11. Charges for common first-aid supplies such as adhesive tape, gauze, antiseptics, and ace bandages.
12. Charges for non-prescription drugs (except insulin for treatment of diabetes) and prescription drugs on the Federal Drug Efficacy Study Implementation (DESI) list of ineffective medicines.
13. 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.
14. Charges for facility fees (e.g. abortion clinics, surgical centers) (may be covered by Hospital Benefits, Section 5).
15. Charges for treatment of sexual dysfunction unrelated to organic disease.
16. Charges for Home Health Care services and expenses performed by L.P.N.s, nurses aides, home health care aides, companions, or housekeepers) (may be covered under Hospital Benefits, See Section 5).
17. Charges for sanitarium, custodial, convalescent, rest cure and non-skilled nursing care.
18. Charges for confinement in a Hospital, medical center or similar facility, or for any program or out-patient care for substance abuse.
19. Charges for a stand-by surgeon or stand-by anesthesiologist.
20. Charges for refractive keratoplasty services.

SECTION 7 WEEKLY DISABILITY BENEFIT

Weekly Disability benefits are provided to Participants only.

If you are unable to work in Employment due to Sickness or Injury not connected with your job and are under the care of a Physician, you are eligible for Weekly Disability benefits. If your Disability is a result of drug or alcohol abuse, Weekly Disability benefits are payable if you are in a 30-day in-patient treatment plan and then have follow-up out-patient treatment with a Physician or licensed therapist.

The Fund does not contact your Employer. You must notify your Employer when you will be out from work and when you will return to work.

A. AMOUNT OF WEEKLY DISABILITY BENEFITS.

The amount payable as Weekly Disability benefits is 50% (one-half) of your weekly earnings for the week preceding the date of Disability. Employees of the Union, the Division 1181 Credit Union, the Division 1181 A.T.U. — New York Employees Pension Fund, and this Fund will receive the rate applicable to drivers. The maximum weekly payment is based on your time in Employment as follows:

1. If you have been employed for less than 12 continuous months, you can receive up to the maximum statutory amount (currently \$200 maximum per week for drivers and \$175 per week for matrons), for up to 26 weeks beginning on your 8th calendar day out of work due to Disability.
2. If you have been employed for at least 1 year but less than 2 years, you can receive up to the maximum statutory amount (currently \$200 maximum per week for drivers and \$186.95 per week for matrons) for up to 52 weeks, beginning on your first day out of work due to an Injury or hospitalization, if hospitalization immediately follows the last day you worked, or the fourth day you were out of work due to Sickness. For Disabilities due to Injury or Sickness that are covered by No-Fault Insurance, the maximum period that is payable is 26 weeks.
3. If you have been employed for 2 or more years, you can receive up to the maximum statutory amount (currently \$250 per week for drivers and \$200 per week for matrons) for up to 52 weeks, beginning on your first day out of work due to an Injury or hospitalization if hospitalization immediately follows the last day worked, or the fourth day out of work due to Sickness. For Disabilities due to Injury or Sickness that are covered by No-Fault Insurance, the maximum period that is payable is 26 weeks.

Medical Benefits While Receiving Weekly Disability.

- If you are Disabled due to an Injury not covered by No-Fault insurance and you continue to receive Weekly Disability benefits from the Fund, you will continue to be covered as a Participant as long as you receive Weekly Disability benefits.
- If you have been employed less than one year or you are Disabled due to an Injury covered by No-Fault insurance, and you receive Weekly Disability benefits from the Fund for a period of 26 weeks and continue to be totally Disabled, Weekly Disability payments will stop. However, all other benefits provided by the Fund will continue for up to another 26 weeks (as long as you remain Disabled) only for any unrelated Injury or Sickness.
- If you have been employed more than one year, are unable to work due to an Injury or Sickness covered by No-Fault insurance, and you receive Weekly Disability benefits from the Fund for a period of 26 weeks, Weekly Disability payments will stop. However, you will be entitled to all other benefits for up to another 26 weeks only for any unrelated Injury or Sickness as long as you remain Disabled.

- However, your Fund coverage will always end if your Employer is no longer obligated under the CBA to make contributions to the Fund on your behalf during your leave (e.g., if your Employer goes out of business).

You should be treated by a Physician as soon as possible and file your claim promptly. **Your claim form must be received by the Fund Office within 30 days after a covered Disability begins.**

You remain eligible for Weekly Disability benefits if you become Disabled within 4 weeks after the end of the school year.

You remain eligible for Weekly Disability benefits if you become Disabled within 4 weeks after termination of Employment (other than due to the end of the school year) for a total of 26 weeks. However, you are not eligible for any health benefits if you become Disabled within 4 weeks after the termination of Employment. (You will be eligible to elect to continue medical coverage under the COBRA continuation coverage rules — *See* Section 15.)

If you become Disabled after having been unemployed for more than 4 weeks, (including unemployment during the summer months) the Fund will not pay Weekly Disability benefits, but disability benefits may be payable by the Workers' Compensation Board Special Fund for Disability benefits for up to 26 weeks. If you have been employed for more than one year and you remain Disabled, you will be eligible for Weekly Disability benefits from the Fund for up to an additional 26 weeks after you receive disability benefits from the Workers' Compensation Board Special Fund for Disability Benefits, provided that you submit proof of payment from the Workers' Compensation Board Special Fund of your disability dates. You will continue to be covered as a Participant as long as you receive disability benefits from the Workers' Compensation Board Special Fund or Weekly Disability benefits.

If you apply for Workers' Compensation benefits and your claim is controverted or disputed, refer to the "Workers' Compensation Cases" section for instructions (*See* Section 7(C)).

Periods of disability for the same or related conditions are considered a continuous period unless separated by 90 days. If your pay from your Employer is continued due to sick leave, vacation or compensatory time off, Weekly Disability benefits from the Fund will not start until payment from your Employer ceases. Disability benefits will not be paid by the Fund if you are receiving Unemployment Insurance Benefits.

The Trustees have the right, in their discretion, to refer all Weekly Disability benefits claimants for examination by an independent Physician before and after treatment.

B. PAYMENT FOR CHRISTMAS AND EASTER WEEKS.

If you are not "a 52-week per year" Employee, you must be continuously Disabled for ninety (90) days prior to Christmas or Easter Week in order to receive Disability benefits for Christmas or Easter Weeks. There are three exceptions to this rule. Weekly Disability benefits will be paid for the Christmas or Easter week if:

1. You have been hospitalized for non-elective surgery;
2. You have been employed less than 1 year; or

3. Your Disability was caused by an accident or if you have filed a No-Fault insurance claim.

Disability benefits will not be paid by the Fund if you are receiving Unemployment Insurance benefits.

You must be under the care of a Physician, Podiatrist, Chiropractor, Dentist, nurse-midwife or psychologist in order to receive Weekly Disability benefits. Periodically, your health care provider must certify that you are still unable to work as a condition of receiving Weekly Disability benefits. If the Fund does not receive information regarding Disability from you, Weekly Disability benefits will be suspended until it is received. If the information shows you are still Disabled, Weekly Disability benefits will be paid for the period of suspension.

If your pension begins from the Division 1181 A.T.U. — New York Employees Pension Fund, your Weekly Disability benefits will terminate effective with your pension benefit commencement date. You will not be entitled to Weekly Disability benefits for the same period you are receiving a pension benefit.

C. WORKERS' COMPENSATION CASES.

If your Disability arises from a work-related Sickness or Injury, you should notify your Employer immediately and file a claim for Workers' Compensation benefits. You must also advise the Fund of the date of your accident/Sickness and submit a copy of all information received from the Workers' Compensation Board to the Fund Office.

A Sickness or Injury that is compensable by Workers' Compensation insurance is excluded from coverage under the Plan. However, if your claim for Workers' Compensation insurance is controverted or disputed, you will receive a W.C.B. Form C-7 from your Employer's Workers' Compensation insurance carrier. To receive benefits from the Fund, you must contact the Fund Office immediately upon receipt of a W.C.B. Form C-7. The Fund will send you a Weekly Disability benefits form, W.C.B. Form DB-450, which must be completed and returned to the Fund Office together with the W.C.B. Form C-7. If you continue to be Disabled, Weekly Disability benefits will be advanced by the Fund for a maximum of 26 weeks or 52 weeks, whichever is applicable, together with full medical benefits under the Plan, until a decision is made by the Workers' Compensation Board, as long as you meet the following conditions:

1. You file a claim with the Fund on time. (Please note that if you timely file a workers' compensation claim, you will be deemed to have met the Fund's timely filing requirement for Weekly Disability benefits.
2. You submit a copy of the written denial from your Employer or your Employer's insurance carrier. The denial must state that the claim is not compensable under Workers' Compensation.
3. You agree in writing on a form provided by the Fund to appeal the denial of your Workers' Compensation claim to the Workers' Compensation Board for final adjudication within the deadline provided.
4. You take all procedural actions necessary to pursue your appeal of the denial from your Employer or your Employer's insurance carrier with the Workers' Compensation Board.

5. You notify the Fund of the date of your Workers' Compensation Board hearing when scheduled, and you attend.
6. You obtain approval from the Fund Office prior to any settlement of your claim.
7. If the Workers' Compensation Board determines that your claim is compensable, the advancing of Weekly Disability benefits terminates and all payments made by the Fund must immediately be returned. In addition, medical payments for work-related injuries must be returned and the Fund may request a reimbursement of these benefits from you, the provider or the Workers' Compensation Board. However, if these amounts cannot be recovered from other sources, you are responsible to pay back these amounts. In addition, depending on the terms of your CBA, you also may be responsible to pay back all medical claims for any period in which, under your CBA, you are not entitled to Fund coverage because your Injury was later determined to be work-related.
8. If the Workers' Compensation Board denies your claim as non-compensable, for a reason other than your failure to appear or your failure to follow necessary procedures, and you do not appeal, you may keep any payments advanced to you.
9. If you receive any recovery, whether by judgment, settlement, or compromise, your claim will be considered compensable and you must repay the Fund the payments advanced to you.
10. You must sign the Fund's forms agreeing to comply with these procedures.

If you fail to file an appeal of the denial from your Employer or your Employer's insurance carrier within 30 days from the date the original claim is denied, all benefits will terminate and payments made by the Fund to you must be immediately returned. Contact the Fund Office if you have questions concerning the Fund's payment of claims if your disability has been controverted by the Workers' Compensation Board.

SECTION 8 DENTAL BENEFITS

The Fund pays up to a maximum of \$2,000 per year for Dental expenses incurred by Participants and/or Dependents age 19 or over in accordance with the Schedule of Dental benefits; however, there is no annual limit on dental benefits for Dependent children age 18 and under if required by law. Dental claims and questions should be directed to the Fund Office.

Procedures: When a Participant goes to a Dentist, the Participant can elect to either have (1) the Fund pay the Fund allowance for the service and have the Dentist balance-bill the Participant for the rest or (2) the Participant can pay the full Dentist charge, file a claim for reimbursement with the Fund Office, which will in turn pay the Participant directly the Fund Allowance for the service.

SCHEDULE OF DENTAL BENEFITS

<u>DESCRIPTION OF PROCEDURE</u>	<u>FUND ALLOWANCE</u>
DIAGNOSTIC	
Oral Examination	
Consists of charting, completion of forms and oral examination (twice per year)	\$ 30.00
Radiographs	
Complete intra-oral series (consists of 14 periapical and four bite-wing films once every three years)	\$ 50.00
Intra-oral single first film (periapical)	\$ 5.00
Intra-oral each additional periapical film	\$ 2.00
Four regular bite-wing films	\$ 15.00
Two regular bite-wing films	\$ 10.00
Single regular bite-wing film	\$ 5.00
Panorex (once every 3 years)	\$ 50.00
Occlusal films (usually used in edentulous cases) each	\$ 15.00
Lateral jaw x-ray to be used as aid to complex surgical procedures	\$ 50.00
Anterior-posterior x-ray of head and jaw (justification required) for specialists only	\$ 50.00
*Note: Total of individual films may not exceed allowable number for complete series.	
PREVENTIVE	
Oral Prophylaxis (twice per year)	
Adults (age 12 and over)	\$ 25.00
Children (under age 12)	\$ 15.00
Scaling, curettage, and root planning	\$ 20.00
	per quadrant
	\$ 320.00
	maximum
	per year
Fluoride treatments — ages 4 to 14 years:	
Topical application of stannous fluoride — two treatments annually	\$ 20.00
Sealants — ages 4 to 14 on posterior permanent teeth	\$ 15.00
Space Maintainers	
Fixed, Band type	\$ 50.00
Fixed Stainless Steel Crown Type	\$ 50.00
Removable Cast-chrome Cobalt types (with clasps)	\$ 70.00
Removable Acrylic Type (with clasps)	\$ 60.00
RESTORATIVE	
Amalgam Restorations	
Amalgam — one surface	\$ 25.00
Amalgam — two surfaces	\$ 35.00
Amalgam — three surfaces or more	\$ 50.00
	maximum
Composite Restorations or similar accepted materials (per restoration)	
One surface	\$ 35.00
Two surfaces	\$ 45.00
Three surfaces	\$ 55.00
Four surfaces or more	\$ 75.00

DESCRIPTION OF PROCEDURE**FUND ALLOWANCE**

Double occlusal fillings are considered one restoration. Slight buccal and lingual extensions of occlusal surface are considered one restoration. Cement bases, pulp capping, acid etch, and all protective agents are included in fee for restoration. Posterior teeth filled with composite or similarly accepted filling materials will be paid as amalgam fillings.

Inlays

One surface.....	\$	50.00
Two surfaces.....	\$	60.00
Three surfaces.....	\$	75.00
Recementing inlay (must be serviceable).....	\$	15.00

Reinforcement pins (Two Pins Maximum Per Tooth)

First pin.....	\$	20.00
Second pin in the same tooth.....	\$	10.00

Crowns (single restoration only)

Stainless steel crown.....	\$	50.00
(To be used on deciduous teeth or where permanent restoration on permanent tooth is not feasible due to age of patient or enlarged pulp. Three surfaces of tooth must be involved.)		
Porcelain fused to metal crown	\$	350.00
Laminate	\$	250.00
Full Cast gold crown	\$	250.00
Acrylic veneer crown	\$	250.00
Porcelain jacket crown	\$	250.00
Acrylic jacket (lab processed)	\$	50.00
Three quarter crown	\$	75.00
Recement Crowns (must be serviceable)	\$	20.00

Palliative Treatment (emergency treatment of dental pain with no other treatment in same visit)

\$ 20.00

PERIODONTAL SURGICAL PROCEDURES

Osseous surgery – Requires Prior Approval	\$	150.00
		per quadrant
Gingivectomy	\$	100.00
		per quadrant

MAXIMUM ALLOWANCE FOR PERIODONTAL SURGERY \$ 600.00

Periodontal maintenance

\$ 50.00

Note: When multiple surgical procedures are performed in the same quadrant, only the most comprehensive will be covered.

ENDODONTICS**Pulpotomy**

Limited to deciduous teeth only — If tooth is not ready to be exfoliated.... \$ 50.00

Root Canal Therapy Pre- and post-operative x-rays are required.

Tooth with one canal	\$	175.00
Tooth with two canals	\$	225.00

<u>DESCRIPTION OF PROCEDURE</u>	<u>FUND ALLOWANCE</u>
Tooth with three or more canals.....	\$ 300.00
Apicoectomy.....	\$ 175.00
If more than one root requires apicoectomy, allowance for one root is \$175.00; allowance for second and third root is \$100.00 each root.	
Retrograde Filling – per root.....	\$ 25.00
Root Resection.....	\$ 100.00
Hemisection.....	\$ 100.00

PROSTHODONTICS:

REMOVABLE The Fund does not cover temporary or transitional dentures.

Full upper denture.....	\$ 350.00
Full lower denture.....	\$ 350.00

Immediate full upper or full lower denture shall be considered a final denture.

Bilateral upper or lower partial cast chrome acrylic attachments, cast clasps with rest	\$ 375.00
Unilateral partial upper or lower cast chrome acrylic attachments, cast clasps with rest	\$ 200.00

Chair side relines rendered in the first three months at no additional fee. **All these procedures require prior approval, except chair side relines.**

Relines or Rebases – Limited to one procedure per year

Upper or full lower dentures, lab processed.....	\$ 125.00
Partial denture relines, lab processed	\$ 100.00

Denture Repairs

Denture repair	\$ 45.00
Adding tooth or teeth to partial denture replacing extracted tooth or teeth:	
First tooth.....	\$ 40.00
Each additional tooth.....	\$ 15.00
Repair Cast Framework.....	\$ 50.00
Adding clasp to existing partial	\$ 50.00
Partial denture repair involving replacement of broken clasp with a new clasp and rest	\$ 50.00
Replacing buccal or lingual arm.....	\$ 35.00

Fixed Bridgework

Porcelain pontic	\$ 250.00
Acrylic pontic	\$ 200.00
Cast pontic	\$ 200.00
Recement bridge (must be serviceable).....	\$ 40.00
Replace facing-lab processed	\$ 75.00
Acrylic veneer crown	\$ 250.00
Porcelain crowns	\$ 350.00
Cast post and core.....	\$ 150.00
Prefabricated post and core (metal).....	\$ 100.00
Crown build-up.....	\$ 100.00
Maryland abutment.....	\$ 100.00

DESCRIPTION OF PROCEDURE**FUND ALLOWANCE****ORAL SURGERY**

Routine Extractions per tooth.....	\$ 50.00
Root removal (exposed root).....	\$ 50.00
Palliative (Emergency) Treatment of Dental.....	\$ 25.00
General Anesthesia.....	\$ 100.00
Incision and drainage.....	\$ 50.00
Frenectomy.....	\$ 50.00
Removal of cyst, lab report required (included in fee).....	\$ 150.00

MULTIPLE EXTRACTIONS

Surgical Extraction.....	\$ 75.00
Soft tissue impaction.....	\$ 75.00
Partial bony impaction.....	\$ 100.00
Completely bony impaction.....	\$ 150.00

Alveolectomy

Per tooth.....	\$ 10.00
Per quadrant.....	\$ 60.00
Maximum per jaw.....	\$ 120.00
Alveoplasty.....	\$ 10.00

PROCEDURES, LIMITATIONS AND EXCLUSIONS

If prior approval is required for the procedure, and is not obtained, benefits will not be paid.

Covered Persons are required to submit full series of mounted X-rays and invoices, properly charted with treatment plan, to obtain prior approval where required. In edentulous cases, occlusal films must be submitted in order to obtain prior approval.

The Fund will pay \$50 annually towards the cost of a consultation with a qualified specialist if requested by the Dentist for each Covered Person before and/or after treatment as the case warrants.

Maximum fee for repairs of prosthetic appliances (bridges, dentures, partials, crowns, etc.) is \$100 per calendar year for any Covered Person, except to the extent prohibited by law.

The Trustees have the right, in their discretion, to refer all dental claimants for examination by an independent Dentist before and after treatment.

In addition to the exclusions applicable to all forms of benefits under the Plan (Section 4), dental benefits do not cover:

1. Temporary or transitional dentures;
2. Full mouth, crown and bridge restoration;
3. The replacement of fixed bridges, full or partial dentures, crowns, or any prosthetic appliance if payment toward the cost of original appliance was made by the Fund unless 3 years have elapsed from date of original insertion;

4. Crowns constructed for the purpose of receiving a precision or semi-precision attachment for any prosthetic appliance or for clip on bars;
5. Splinting of periodontally involved teeth with questionable prognosis by means of crowns, inlays or any other appliance, be it during or after treatment;
6. Dental work performed only for cosmetic purposes except to correct a condition resulting from accidental Injury to natural teeth; and
7. Orthodontia.

SECTION 9 PRESCRIPTION DRUG BENEFIT

The Fund has a contract with Express Scripts to have prescriptions filled at a pharmacy or by mail order.

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 copayment for generic drugs, a \$15 copayment for preferred brand-name drugs, and a \$30 copayment for non-preferred brand drugs. A list of preferred and non-preferred brand name drugs for this Plan can be found at www.expressscripts.com. Refills will be provided in accordance with your prescription and state law. For a prescription you take on an ongoing basis (i.e. for more than 3 months), you may use a participating retail pharmacy for your initial prescription and up to 2 refills (for a total of 3 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 copayment for each prescription filled at a retail pharmacy. The higher copayment is \$20 per prescription for generic drugs, \$60 for preferred brand-name drugs, and \$120 for non-preferred brand name drugs.

Please note that almost all specialty medications must be submitted through Accredo, one of Express Scripts' mail order pharmacies, and cannot be filled at retail. (There are a few specialty drugs that can be obtained at retail; please contact Express Scripts for more information on these specific drugs.) You will be charged the mail order copayment for these specialty drugs.

In the event that you do not use a participating pharmacy, you should obtain a receipt and apply to Express Scripts for direct reimbursement. You can order claim forms and envelopes through Express Scripts' website, www.expressscripts.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.

A number of drugs are not part of the Fund's formulary of covered drugs and will not be covered at all. However, there are alternative drugs as a replacement for any drug that is excluded from the formulary. If one of the alternative drugs cannot properly treat your condition, your Physician and you may request a determination that one of the excluded drugs is Medically Necessary, after having used one of the covered medications. Please contact Express Scripts at the number on your member ID card for information on the process to apply for a Medically Necessary exception or to obtain a list of the covered drugs on the formulary.

When a generic drug is available, but the pharmacy dispenses a brand name drug at you and your Physician's request, you will pay the difference between the cost of the brand drug and the cost of the generic drug.

B. THE HOME 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. Through the Home Delivery Pharmacy Service, you pay your applicable copayment for up to a 90-day supply of generic or brand medications. You pay a \$12.50 copayment for generic drugs, a \$37.50 copayment for preferred brand-name drugs, and a \$75.00 copayment for non-preferred 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 of your medication, 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 an Express Scripts mail order form and envelope. If you need to request order forms and envelopes, go online anytime at www.expressscripts.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 (888) 327-9791 for instructions on how to use our 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 (800) 711-0917 to use the automated refill system; or
- Mail your refill slip and appropriate copayment in the special order envelope; or
- Visit the Express Scripts website at www.expressscripts.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 Express Scripts website at www.expressscripts.com or by calling Member Services at (800) 711-0917.
- If you are provided mail-order pharmacy drugs and you did not make a copayment, you are still responsible for making a copayment 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 Express Scripts during regular business hours by calling toll free (800) 711-0917 or the Fund Office at (718) 845-5800. You also can contact Express Scripts through their website, www.expressscripts.com.

C. CLINICAL DRUG MANAGEMENT

1. Prior Authorization

Prior authorization is the process to obtain approval for particular medications. ESI evaluates whether or not to approve these requests based on a set standard or protocol, to make sure drugs are being used for clinically appropriate purposes, including but not limited to whether or not the drug is Medically Necessary. If a drug you wish to take is subject to prior authorization, please have your Physician contact ESI and provide the appropriate documentation for review. Please go to www.express-scripts.com or contact Express Scripts by phone for a list of drugs subject to these rules. Again, this list will be changed from time-to-time based on new drugs coming to market and clinical recommendations.

2. Drug Quantity Management

Drug Quantity Management means that the Fund will only pay for a set quantity amount at a particular strength for certain drugs. Quantity limits are set in accordance with FDA approved prescribing limitations and standard medical practice. Please go to www.express-scripts.com or contact Express Scripts by phone for a list of drugs subject to these rules. This list will be changed from time to time based on new drugs coming to market and clinical recommendations. If your Physician wants to prescribe a particular strength of drug that is contrary to the limits imposed, your Physician can request prior authorization for approval of this drug, as described below.

3. Step Therapy

“Step therapy” requires Participants to use generic or lower-cost brand name drugs first to treat a condition before the Fund will cover a more expensive brand name drug for the same condition. These generic or lower-cost brand drugs (called “front-line drugs”) are generally more cost-effective for you and the Fund, and provide the same level of benefit. If you attempt to fill a prescription for a drug that is subject to step therapy before using a front-line drug, it will be denied. Please go to www.express-scripts.com or contact Express Scripts by phone for a list of drug categories subject to step therapy, as well as the front-line drugs for each category. From there, your Physician can determine which front-line drugs covered by the Fund are right for your condition.

The Fund will cover a more expensive brand drug to treat a condition if you have already tried the front-line drugs and they are ineffective for treating your condition, or you cannot take the front-line drugs for some other reason (e.g., a medical allergy). If this is the case, please have your Physician submit a prior authorization request to get the brand name drug approved. If the request is granted, you will pay the appropriate copayment for the brand

name drug. If the request is denied, you will either have to pay the full price for the brand name drug or will have to take the front-line drug initially prescribed.

4. Compound Prescription Exclusion

The Fund does not cover compounded medications with certain ingredients because these medications usually cost more than comparable FDA-approved, commercially available drugs, and are not necessarily more effective. If your Physician wants to prescribe a compounded medication, your Physician can submit a prior authorization request to Express Scripts for approval. However, if the request is not granted, you will have to pay full price for the compounded medication. Please go to www.express-scripts.com or contact Express Scripts by phone for a list of ingredients that cannot be compounded.

D. COVERED PRESCRIPTION DRUGS.

The following are covered under the Fund's 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;
6. Retin A and similar products up to 26th birthday; and
7. Injectables (via Mail Order Only), upon approval by the Fund.

E. DRUGS COVERED AT NO COST SHARING.

The Fund covers generic contraceptive medicines at no cost-sharing to Participants if required by law. The Fund also will cover brand contraceptive medicines at no cost-sharing, provided that a generic contraceptive would be medically inappropriate, as determined by your health care provider. Please contact Express Scripts at the number on your member ID card for information on the process to apply for this brand drug exception.

Bowel preparation medicines are covered for Participants and Dependents between the ages of 50 and 75 when prescribed for colorectal screening at no cost-sharing to Participants or Dependents.

The following Over-the-Counter ("OTC") drugs and vitamins are covered at no cost-sharing to Participants and Dependents, provided that you have a prescription: aspirin, fluoride, folic acid, and iron, FDA-approved tobacco cessation medications. There are certain age, gender, and other reasonable medical management limitations on coverage for these OTC drugs and vitamins. For any questions on this benefit, including how to receive reimbursement for these drugs, please contact Express Scripts at (800) 711-0917.

In addition, for Participants and Dependents age 65 and older only, Vitamin D2 or D3 containing 1,000 IU or less, and dual combination agents containing calcium and Vitamin D2 or D3, are covered at no cost, in either generic or Over-the-Counter form, provided that you have a prescription.

The Fund covers the breast cancer prevention drugs Raloxifene, Tamoifen and Soltamox for women age 35 and older at no cost sharing to Participants and Dependents, provided there is documentation of a preventive diagnosis.

The Fund covers all FDA-approved tobacco cessation medications for adults age 18 or older at no cost sharing to Participants and Dependents, up to a limit of 180 days' supply within a 365 day period.

F. EXCLUDED PRESCRIPTION DRUGS.

The following are excluded from the Fund's Prescription Drug Benefit:

1. Non-prescription items (such as bandages, heating pads, aspirin, etc.) even though a Physician may order them on a prescription pad; however, this exclusion shall not apply to coverage required under Section 9(E);
2. Fertility medications;
3. Implements and any other surgical supplies or devices;
4. Retin A (after Participant's or Dependent's 26th Birthday);
5. Rogaine for baldness, or any drugs whose sole purpose is to promote or stimulate hair growth;
6. Syringes and needles other than insulin syringes and needles including self-injectable cholesterol medications such as PCSK9 inhibitors;
7. Drugs labeled "Caution-limited by Federal Law to investigational use," or Experimental drugs, even though a charge is made to the individual;
8. Food supplements;
9. Non-Federal Legend Drugs;
10. Immunization agents, biological sera, blood or blood plasma;
11. Therapeutic devices or appliances;
12. Medication that is to be taken by or administered to a Covered Person, in whole or in part, while he or she is an inpatient in a Hospital or other similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
13. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after 1 year from the Physician's original order;
14. Expense due to Injury or Sickness that arises out of or in the course of employment;
15. Charges for the administration of any drug;
16. Diagnostic agents;
17. Prescription drugs listed on the Federal DESI list of ineffective medicines;

18. Drugs used to treat sexual dysfunction; and
19. Vitamins that do not carry the Legend: "Caution — Federal (U.S.A.) law prohibits dispensing without a prescription."

SECTION 10 OPTICAL BENEFITS

The Fund provides eye examinations and prescription glasses, if needed, each year for each Covered Person. The Fund has a contract with Vision Screening, Inc. to make optical benefits available at no cost to you or your Dependents. You do not have to use a Vision Screening location but going to a Vision Screening location can save you and your Dependents money. Claims or questions regarding optical benefits should be directed to Vision Screening, Inc., 1919 Middle Country Road, Suite 304, Centereach, NY 11720. Telephone: (800) 652-0063.

OPTICAL BENEFITS:

You and your Dependents are entitled to the following benefits once during every calendar year:

- A. Examination performed by an Optometrist.
- B. Lenses obtainable through prescription and frames, or.
- C. Contact Lenses.

Services and Supplies Provided to Covered Persons By Vision Screening:

- A. **Examination:** An eleven point eye examination, including Glaucoma testing, by an Optometrist who provides visual analysis and determines the corrective prescription. If the Optometrist recognizes pathological or abnormal conditions, the Optometrist will refer the patient to an Ophthalmologist.
- B. **Lenses:** Lenses dispensed by a Vision Screening facility will:
 1. meet FDA impact resistance regulations and the current standards of the American National Standards Institute.
 2. be first quality, corrected curve (in original envelopes) and made in America in Union shops.
 3. be impact resistance glass.
 4. be from a selection of glass lenses in single vision, or toric kryptok bifocals.
 5. Basic lenses will be provided to you at no charge. Your Vision Screening Facility will be able to identify the basic lenses that are covered in full by the Fund. If you chose any special lenses, the Fund will pay up to \$100 towards the cost of those lenses.
- C. **Frames:** Frames dispensed by a Vision Screening facility will:
 1. be from a selection of at least 100 frames for men and women.

2. be available at all outlets.
3. be displayed in one display area.
4. be substituted with a comparable frame if discontinued.
5. be assembled in a Union shop.
6. Basic frames will be provided to you at no charge. Your Vision Screening Facility will be able to identify the basic frames that are covered in full by the Fund. If you chose any special frames, the Fund will pay up to \$100.00 towards the cost of those frames.

D. Dispensing of Eyeglasses:

1. is part of the provision of lenses and/or frames at no additional fee.
2. will be rendered by an Optician who will measure and fit frames and fill the prescription.
3. will meet the current standards of the American National Standards Institute.

E. Adjustments: There is no additional fee for subsequent adjustments.

F. Repairs: There is no additional fee for minor repairs for eyeglasses, not including breakage of lenses, frames or hinges.

G. Discounts on Extras: Individuals identifying themselves as a Participant or Dependent receive a 30% discount on the purchase of other merchandise offered by a Vision Screening facility.

IF YOU DO NOT USE A VISION SCREENING FACILITY.

You may choose any Ophthalmologist, Optometrist or Optician. In this event, the Fund will reimburse up to a maximum of \$25 each year for an eye examination and \$75 (\$40 for frames only; \$35 for lenses only) each year for prescription glasses, upon submission of a reimbursement form provided by the Fund Office.

EXCLUSIONS AND LIMITATIONS.

In addition to the Exclusions and Limitations applicable to all benefits under the Plan (Section 4), Optical Benefits do not cover:

1. More than one examination per calendar year period;
2. More than one pair of lenses per calendar year period;
3. More than one set of frames per calendar year period;
4. Sunglasses, unless prescribed by a Physician;
5. Glasses with tinted lenses, unless prescribed by an Ophthalmologist for medical reasons;

SECTION 11

ANNUAL OUT-OF-POCKET MAXIMUMS

There is a maximum annual limit on what you will have to pay out-of-pocket for certain in-network benefits (called "essential benefits"). Once you reach this out-of-pocket maximum, you will not be responsible for any deductibles, copayments and coinsurance for these in-network essential benefits for the remainder of the year. For 2015, the out-of-pocket maximum for prescription drug benefits is \$3,000 for self-only coverage and \$6,000 for family coverage. The out-of-pocket maximum for essential medical benefits is \$3,600 for self-only coverage and \$7,200 for family coverage. Any out-of-pocket expenses for non-essential benefits, out-of-network costs, and costs for excluded benefits do not count towards this annual out-of-pocket maximum.

SECTION 12

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT

The Fund has a contract with First Unum Life Insurance Company, 2211 Congress Street, Portland, Maine, 04122, for life insurance benefits and accidental death and dismemberment benefits. These benefits are paid through the insurance contract and the insurance company provides claim processing services for these benefits. You will be covered under the insurance carrier and amount of insurance that was in effect on the date you were disabled, or deceased, whichever is applicable.

The Fund provides \$20,000 in life insurance and \$10,000 in Accidental Death and Dismemberment coverage for Participants and \$9,000 in life insurance for Eligible Retirees through Standard Life Insurance Company of New York. The Policy also provides portability and conversion rights when a Participant no longer is eligible for coverage. Please contact First Unum for more details.

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 carrier shall pay the death benefit in accordance with the Fund's life insurance policy.

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 supersede 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 supersede 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.

SECTION 13 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 Plan 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 no other plans involved.** All benefits provided by the Plan (excluding life insurance and accidental death and dismemberment) are subject to these 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. THE PLAN WILL FOLLOW THESE RULES IN DETERMINING WHETHER IT WILL PAY AND THE ORDER IN WHICH IT WILL PAY BENEFITS:

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, a former employee or retiree under one health plan and are covered as a dependent under the other health plan, the health plan covering you based on your employment is primary and the plan covering you as a dependent is secondary.**

Examples of Rule 2 are as follows:

If you are a Participant and your Spouse has coverage as an employee under another health plan:

For you: Your coverage is primary and your Spouse's Dependent coverage is secondary;

For your Spouse: Your Spouse's primary coverage is the other health plan and this Plan's Dependent coverage is secondary.

If you are a Participant and your Spouse has coverage under another health plan and Medicare:

For you: Your coverage is primary and your Spouse's dependent coverage is secondary;

For your Spouse: Your Spouse's primary coverage is the other health plan, this Plan's Dependent coverage is secondary, and Medicare is third.

If you are a Participant and your Spouse has retiree coverage under another plan:

For you: Your coverage is primary and your Spouse's retiree dependent coverage is secondary.

For your Spouse: Your Spouse's retiree coverage is primary and this Plan's Dependent coverage is secondary.

If you are a Participant and your Spouse has retiree coverage under another plan and Medicare:

For you: Your coverage is primary and your Spouse's retiree dependent coverage is secondary.

For your Spouse: Your Spouse's retiree coverage is primary, this Plan's Dependent coverage is secondary, and Medicare is third.

If you are a Participant and your Spouse is a covered retiree under this Plan (with Medicare):

For you: Your coverage is primary and your Spouse's retiree Dependent coverage is secondary;

For your Spouse: This Plan's retiree coverage is primary, the Plan's Dependent coverage is secondary, and Medicare is 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 a Participant and you also have retiree coverage under another health plan:

For you: Your coverage under this Plan is primary and your retiree coverage 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 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 through 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 rules 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 the other health plan(s) will not change the order in which this Plan will pay.**
8. **Other rules of coordination of benefits.**

If you are a Participant's Spouse and you also are a Participant and you receive services from a non-Empire network provider, Coordination of Benefits rules will apply to Major Medical benefits only. In this case, Major Medical charges will be paid at 100% of the Allowable Charge for the procedure for the Participant coverage and then at 20% of the Allowable Charge for the Dependent coverage. In no case will the Fund's total payment exceed the provider's actual charges.

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 HMO or PPO, 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 copayment 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 that plan's 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 full Allowable Charge under this Plan for the claim.

Example #1: That claim is \$400. The 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 primary has paid less than this Plan would pay as primary, this Plan will pay any remaining balance on the claim, up to 100% of the Allowable Charge under this Plan for the claim. This 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 Major Medical Claim is \$400. The 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 the \$100 that the other health plan has paid and \$200 as 100% of the Allowable Charge 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 provide information to the Fund on all other coverage for you and your Dependents, including the company providing the coverage and the policy number.

SECTION 14 COORDINATION OF BENEFITS WITH MEDICARE

Participants Age 65 and Over and Their Dependents.

If you work for an Employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year and the Fund has obtained an exception from CMS for your Employer, then Medicare is primary for you and your Dependents.

Otherwise, the following rules apply:

- A. This Plan will be primary for (1) any person age 65 and older who is an Active Employee and (2) the Spouse of an Active Employee age 65 and older, unless the Spouse has coverage from elsewhere.

- B. You or your Dependent(s) may decline coverage under the Plan and elect Medicare as primary. You will continue to be covered by this Plan as primary until you notify the Fund Office in writing that you wish to elect Medicare as primary, or unless your coverage under this Plan ceases. If you decline coverage under this Plan, this Plan will not pay benefits secondary to Medicare for Medicare covered services.

Disabled Employees or Disabled Dependents Under 65.

This Plan is primary for Participants or their Dependents who are under age 65 and have a Social Security Disability Award that entitle them to Medicare benefits due to their total Disability (other than End Stage Renal Disease).

End Stage Renal Disease.

If you have End Stage Renal Disease, this Plan will be primary for the first 30 months of treatment. 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 15 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, allows Participants and their Dependents to pay for a temporary extension of health coverage (called "Continuation Coverage") at group rates in certain instances ("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 Weekly Disability benefits, Life Insurance and Accidental Death and Dismemberment Benefits.

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

Qualifying Events

If any of the following events result in loss of benefits, the Covered Person will be offered the opportunity for a temporary continuation of benefits coverage at group rates:

- A. Participant's termination of Employment (for reasons other than gross misconduct) or retirement;
- B. Participant's reduction in hours of Employment;
- C. Participant's entitlement to Medicare;
- D. Participant's death;
- E. Participant's divorce;

- F. For a Retiree (*see* the Fund's Retiree SPD), the proceeding in a case under Title 11 of the United States Code, (bankruptcy), by the Employer from whose Employment the Retiree retired.
- G. Participant's legal separation;
- H. A Dependent child ceasing to be a Dependent under the terms of the Plan.

Reporting Requirements

Your Employer must notify the Fund Office if any of these qualifying events occur to you: termination of Employment, reduction of working hours to fewer than 20 hours per week, entitlement to Medicare or death. Your Employer must also notify the Fund Office in the case of the Employer's initiation of bankruptcy proceedings. This notification must be in writing and must be furnished within 30 days of the date of the qualifying event. Failure to provide such timely notification may subject the Employer to federal excise taxes.

Both the Participant and the affected Covered Person must notify the Fund Office in the event of: divorce, legal separation or loss of eligibility for Fund coverage by a Dependent child. This notification must be furnished (preferably in writing) within 60 days of the occurrence of the qualifying event. Failure to furnish such notification within the required 60 days will result in the loss of the right to Continuation Coverage.

Notices should be mailed or hand delivered to the Fund Office. Written notice of a qualifying event must include the following information: name and address of affected Participant and/or beneficiary, Participant'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, or Dependent's birth certificate). Once the Fund receives timely notification that a qualifying event has occurred, COBRA coverage will be offered to Participants and Dependents, as applicable.

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

Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give proper notice within 60 days of the date of the Qualifying Event, or an Employer within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect Continuation Coverage under this provision, then the Covered Person or the Employer, as appropriate, will be obligated to reimburse the Plan for any claims that should not have been paid. If a Covered Person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on your behalf or for any of your other Dependents.

In addition, you or your Dependent must notify the Fund Office immediately if you become covered by any other plan of group health benefits whether through your employment, 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.

If an Employer fails to give proper notice within 30 days of the Qualifying Event as required and the Covered Person is, as a result, permitted to elect, and does elect Continuation Coverage more than 90 days after the date of the Qualifying Event, the Employer is obligated to reimburse the Plan for all claims paid by the Plan on behalf of the Covered Person. The Trustees, in their sole discretion, may limit the application of this subsection where it appears, based on all circumstances, that the Covered Person would have elected Continuation Coverage within 90 days of the Qualifying Event had notice of the right to such an election been provided during the period.

Notice and Election Form

Empire will, within 14 days of receiving notification of a qualifying event, send to the affected Covered Person 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.

Coverage may be continued for any Dependent who is properly covered on the day before the event resulting in loss of eligibility (listed above). Each Dependent has the independent right to elect or reject COBRA continuation coverage. The Participant 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.

In order to obtain Continuation Coverage under the provisions of COBRA, the Notice of Election form must be completed and returned to Empire within 60 days after receipt. Payment of the COBRA payment, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the return of the completed COBRA Notice and Election form. COBRA Notice of Election forms must be sent to the following address: Empire Blue Cross Blue Shield, P.O. Box 660350, Dallas, TX 75266-0350.

Dependent Rights

The Spouse and Dependent child of a Participant will have the right to choose Continuation Coverage, if the Spouse loses coverage under the Plan for any of the following reasons:

- A. the death of the Participant;
- B. termination of the Participant's Employment (for reasons other than gross misconduct), retirement or reduction in the Participant's hours of Employment;
- C. divorce or legal separation of the Participant;
- D. eligibility of the Participant for Medicare.

In addition, a Dependent child of a Participant has the right to choose Continuation Coverage, if he or she loses coverage under the Plan by failing to continue to qualify as a Dependent.

Details of Continuation Coverage

If you choose Continuation Coverage, the coverage provided is identical to the coverage provided under the Plan to similarly situated Covered Persons, except for Weekly Disability benefits, Life Insurance, and Accidental Death and Dismemberment Benefits. If the coverage provided under the Plan is modified after you elect Continuation Coverage, your coverage also will be modified.

Children born to or placed with you for adoption during the COBRA period also may receive coverage for the duration of your Continuation Coverage period, provided you enroll the children in accordance with the Fund's rules. Coverage for newborn or adopted children will continue for the same time as coverage for Dependent children who were properly enrolled in the Fund on the day before the qualifying event. Newborn or adopted children added to your COBRA coverage also become qualified beneficiaries.

Payment Provisions

Under COBRA, you will have to pay the cost for your Continuation Coverage. Continuation Coverage requires timely application for the coverage and timely monthly payments. The payment due date is the first day of the month in which Continuation Coverage begins. For example, payments for the month of November must be paid on or before November 1. The payment due for the initial period of Continuation Coverage will include payment for the period of time dating back to the date on which Plan coverage terminated. Failure to pay the full payment by each due date (or within the 30 day grace period thereafter) will result in loss of all 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 you and/or 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.

Cost of COBRA Coverage

You must pay to continue benefits, as determined by the Fund; the cost will not exceed 102% of the cost of coverage. The cost will be specified in the notice of right to elect continuation of coverage sent to you by Empire. However, the maximum COBRA premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former Employer alters the level of benefits provided through the Fund to similarly situated active employees, your 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

Coverage may continue, on a self-pay basis, as follows:

- A. Coverage for you and/or your Dependent(s) may be continued for up to 18 months, if coverage terminated due to your:
 - 1. termination of Employment, other than for gross misconduct;
 - 2. reduced work hours;
 - 3. retirement.

The 18 month period of Continuation Coverage may be extended up to an additional 11 months if the Social Security Administration determines that you or your Dependent were disabled at the time of the Qualifying Events described above (or within 60 days of the Qualifying Event). **Proof of disability must be provided to the Fund within 60 days of the date the Social Security**

Administration makes the determination and within the original 18 month COBRA period. This extended period of Continuation Coverage also applies to your nondisabled Dependents. If the Social Security Administration determines during the initial 18 month period that the person is no longer disabled, the 11 month extension does not apply.

If the Social Security Administration determines after the initial 18 month period that the person is no longer disabled, the period of Continuation Coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, so long as the period of Continuation Coverage does not exceed 29 months.

- B. Coverage of your Dependent(s) may be continued for up to 36 months, if coverage terminated due to:
 - 1. your death;
 - 2. divorce or legal separation;
 - 3. with respect to your Dependent child, his or her ceasing to satisfy the Plan's definition of a Dependent; or
 - 4. for a Retiree (*see* the Fund's Retiree SPD), the proceeding in a case under Title 11, United States Code (bankruptcy) by the Employer from whose Employment the Retiree retired.
- C. If your Dependent's coverage is continued for 18 months as a result of a qualifying event listed in paragraph (A) of this section and, during the continuation period, a qualifying event occurs which entitles the Dependent to continue coverage under paragraph (B) of this section, your Dependent may elect to continue coverage for up to a combined maximum of 36 months.
- D. If you become entitled to Medicare while you are a Participant, and within 18 months of becoming entitled to Medicare, you become entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for your Dependents may be continued for up to 36 months from the date you became entitled to Medicare. However, if you elect COBRA coverage for 18 months as a result of a qualifying event listed in paragraph (A), and during that 18-month period you become entitled to Medicare, this is not considered a secondary qualifying event that will extend your Dependents' coverage for up to 36 months from the date of the first qualifying event.
- E. **If you elect Continuation Coverage under COBRA upon termination of your Employment and you are eligible to begin receiving a pension benefit immediately, you will be eligible for retiree health benefits when you do retire. If you elect Continuation Coverage under COBRA upon termination of your Employment before you are eligible to begin receiving a pension benefit immediately, you will not be eligible for retiree health benefits when you do retire. (*See* the Fund's Retiree SPD.)**

Termination of Continuation Coverage

If you and/or your Dependent(s) do not elect Continuation Coverage, you and/or your Dependent's Fund coverage will end.

If you and/or your Dependent(s) elect Continuation Coverage, Fund coverage will cease on the first of the following dates:

- A. The date the Fund terminates;
- B. The date a required payment is due and remains unpaid after the applicable grace period;
- C. The date you and/or your Dependent(s) first become insured under another group health plan as long as it is after the Qualifying Event. Contact the Fund Office for additional information when you and/or your Dependent(s) become insured under another group plan;
- D. The date you or your Dependent(s) first become eligible for Medicare as long as it 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;
- E. The date the applicable period of Continuation Coverage is exhausted; or
- F. The first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for 11 months, so long as the period of Continuation Coverage does not exceed 29 months.
- G. If your Employer stops participating in the Plan, your continuation coverage will end on the date your Employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under this Plan.

Once your COBRA coverage terminates for any reason, it cannot be reinstated. You or your Dependents can only become covered under the Plan again if you return to Active Employment and meet the Plan's eligibility requirements.

Contact for Additional Information

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

SECTION 16 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. Even if you are not eligible for Employer paid Dependent coverage, your child under a QMCSO will be automatically enrolled in Dependent coverage and you will have to make the pre-tax payroll deduction under Section 2(B) of this SPD. You can request a copy of the Fund's procedures for determining whether an order is a QMCSO without charge.

A QMCSO may require that accidental death and dismemberment benefits payable by the Fund be paid to satisfy child support obligations with respect to your child. If the Fund receives such an order and benefits are currently payable, or become payable in the future while the order is in effect, the Fund will make payments either to the Child Support Agency, or the recipient listed in the order.

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 the 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 placed for adoption with you for whom Dependent coverage is requested has actually been placed with you for adoption.

SECTION 17

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to Participants who are absent from Employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

A Participant who is absent from Employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which the Participant is required to but fails to apply under USERRA for or return to a position of Employment covered under the Fund. (For example, for periods of service over 180 days, generally the Participant must reapply for Employment within 90 days of discharge.)

This right to temporarily continue group health coverage does not include any life insurance benefits, accidental death and dismemberment benefits, accident and sickness benefits or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, Participants and/or Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please refer to Section 14 of this SPD for more information.

If the Participant met the Plan's eligibility requirements at the time he or she entered the uniformed services, the Participant will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from uniformed service, as required under USERRA.

Notice and Election of USERRA Coverage

The Participant must notify his or her Employer or the Fund Office of the absence from Employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Fund Office within 60 days of the last day of Employment unless the Participant is excused from giving advance notice of service under the provisions of USERRA. While an Employee may notify an Employer of service orally, the Fund requires that Participants elect USERRA coverage in writing. The Fund will provide you with the necessary forms.

Paying for USERRA Coverage

The Participant may be required to pay all or a portion of the cost of these benefits. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal deductible or copayments that would be paid if the Participant were employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA 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 USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to make timely payment of all required payments. The Fund will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

SECTION 18 THE FAMILY AND MEDICAL LEAVE ACT ("FMLA") CONTINUATION OF COVERAGE

The Family and Medical Leave Act of 1993 ("FMLA") requires Employers with 50 or more employees to provide you with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of your child or for you to care for your illness, or to care for a seriously ill child, Spouse or parent.

In compliance with the provisions of the FMLA, your Employer is required to maintain your coverage under the Plan during your period of leave under the FMLA just as if you were an Active Employee. Your coverage under the FMLA will cease once the Fund is

notified or otherwise determines that you have terminated Employment, exhausted your 12 week FMLA leave entitlement, or you inform the Fund of your intent not to return from leave, or your Employer ceases to make contributions to the Fund on your behalf during the period of FMLA leave. Please note that even after you exhaust your 12-week FMLA leave entitlement, the Plan will provide an additional 30 days' worth of coverage under the Plan, as long as your Employer approves the additional leave, contributes to the Fund on your behalf during that time, and the leave would have otherwise met the requirements of FMLA leave.

If you are on FMLA leave due to care for an injured military service person, you may be entitled to up to 26 weeks of FMLA leave. Contact the Fund Office if you think this applies to you.

Once the Fund is notified or otherwise determines that you are not returning to Employment following a period of FMLA leave, you may elect continued coverage under the COBRA continuation of coverage rules. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to Employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition that affects you or a family member and which would normally qualify you for leave under the FMLA. If you fail to return from FMLA leave for impermissible reasons, the Fund may offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of the benefits paid on your behalf during the period of FMLA leave.

Effective January 16, 2008, the FMLA also requires Employers with 50 or more employees to provide Participants with up to 12 weeks per year of unpaid leave in the case of a qualifying exigency that arises in connection with the active military service of a child, Spouse, or parent. Please contact the Fund Office for more information on what constitutes a qualifying exigency. In addition, effective January 28, 2008, Employers with 50 or more employees must also provide Participants with up to 26 weeks of unpaid leave during a single year to care for a child, Spouse, parent or next of kin (i.e., nearest blood relative) who is a member of the Armed Forces and is either undergoing medical treatment or is on a temporary disability retired list as a result of a serious injury or illness. To qualify, the injury or illness must have been sustained in the line of military duty and rendered the service member medically unfit to perform his or her duties.

SECTION 19

GENERAL CLAIMS AND APPEALS PROCEDURES

A. TO FILE A CLAIM:

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 Empire customer service at 1-866-513-2473.

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 first, and receive any reimbursement later. 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 (866) 513-2473 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 EOB with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

If you need to file any dental, out-of-network optical, or disability claims, you may request forms to file those claims from the Fund Office.

All Claims must be received no later than 12 months from the date in which services were rendered (except for weekly disability claims). For example, claim forms for services rendered on July 1, 2015 must be received no later than July 1, 2016. FILE YOUR CLAIM AS SOON AS POSSIBLE. If you have any questions about filing your claim, contact the Fund Office at (718) 845-5800.

Some Physician and Hospital charges may be more than the Allowable Charge under the Plan. In that case, you (or the patient) are responsible for any additional amounts billed by the Provider that are not paid by the Fund. If you use an Empire Preferred Provider, refer

to the first paragraph of Sections 5 and 6, for more information about these allowances and charges.

Claims and Appeals Procedures for Life Insurance and Accidental Death and Dismemberment

Life Insurance benefits and Accidental Death and Dismemberment benefits under the Fund are provided pursuant to an insurance contract between the Fund and First Unum Life Insurance Company. For a description of the procedures that you must follow in order to submit a Life Insurance claim or Accidental Death and Dismemberment claim, and the procedures you must follow in order to appeal the denial of a Life Insurance claim or Accidental Death and Dismemberment claim, please refer to your First Unum Life certificate of insurance or contact First Unum at 2211 Congress Street, Portland, Maine, 04122.

B. General Claims Procedures for Medical, Prescription Drug, Vision, Dental, and Weekly Disability Benefits

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.

Empire processes medical and Hospital claims under the Plan on the Fund's behalf, and Vision Screening and Express Scripts process the Fund's optical and prescription drug benefits claims, respectively. The Fund Office will process any dental, out-of-network optical, or Weekly Disability Benefits claims. **Appeals for all benefits will be decided by the Board of Trustees.** Please note that even though this section refers to the "Fund," depending on the type of benefit, other entities (as described above) may be responsible for processing claims within the appropriate time limits as described in the next section. The Fund's procedures and time limits for processing 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.

1. **Initial Claim Review.** The length of time required to process the 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 5 of this SPD, 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 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 15 days after the claim is received by the Fund. The Fund may extend the period for a decision for up to 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 15 day period. The notice of an extension will indicate 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 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 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 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 48 hours, to provide the requested information. The Fund will notify you of its decision as soon as possible, but not later than 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 written notice of the same information within 3 days of the oral notice.

If you do not provide the information requested, or do not properly refile 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 24 hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least 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 30 days after the claim is received by the Fund. The Fund may extend the period for a decision for up to 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 30 day period. The notice of an extension will indicate 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 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.

Weekly Disability Benefit Claims. If the Fund denies your weekly disability benefit claim, in whole or in part, the Fund will send you a notice of the denial within a reasonable period of time, but not later than forty-five (45) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to thirty (30) 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 forty-five (45) day period. The notice of an extension will indicate the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. The Fund may also extend the period for a decision for up to a second extension of thirty (30) 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 first thirty (30) day extension period. The notice of an extension will indicate the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. In addition, any notice of an extension will indicate the circumstances requiring an extension of time, an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve these issues.

If an extension is necessary due to your failure to submit the information required to decide the claim, 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 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.

2. Additional Initial Claim Procedures

Upon request, the Fund will provide you with the diagnosis codes, treatment codes and their corresponding meaning in connection with any adverse benefit determination made by the Fund. However, making this request is not an appeal; *See* Section 19(B)(3) for the procedures on how to appeal an adverse benefit determination.

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

3. Appeal Procedures

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees as explained below. Your appeal must be in writing and must be sent to the Board of Trustees at the address above. An appeal of an Urgent Care claim (see above) may also be made by telephone by calling (888) 513-2473.

If your claim for benefits has been wholly or partially denied, you will have 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 will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than 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 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 your 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. However, 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, but only if you exhaust your administrative remedies by appealing the denial to the Board of Trustees. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in Section 23 of this SPD.

If you wish to file suit for a denial of a claim of benefits, you must do so within 3 years of the date the Trustees denied your appeal. For all other actions, you must file suit within 3 years

of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the Eastern District of New York, Brooklyn Courthouse. These rules apply to you, your Spouse, Dependent, or beneficiary, and any provider who provided services to you or your Spouse, Dependent or beneficiary. This Section applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

For Hospital, medical, optical and prescription drug benefits, before you appeal to the Board of Trustees, you may wish to contact the appropriate Fund provider listed below with any questions or concerns you have regarding your claim denial. If you choose to do so, please contact the provider directly for important information regarding the appropriate procedures, including any time limits. However, if you choose to address your concerns to the provider, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of Trustees, you must appeal to the Board of Trustees within 180 days of the denial of your benefit. If you have addressed your concern to the provider, but have not obtained a response before the end of 180 days from the denial of your benefit, you must file an appeal with the Board of Trustees before the end of that one 180 day period to preserve your right to appeal.

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

Optical Benefits:

Vision Screening, Inc.
1919 Middle Country Road, Suite 304
Centereach, NY 11720

Prescription Drug Benefits:

Express Scripts
P.O. Box 2824
Clinton, IA 52733-2824
Attention: Direct Claims

If your claim for Weekly Disability benefits is denied in whole or in part (or if benefits are reduced or terminated), in addition to your right to appeal to the Board of Trustees, you also have the right to request a review of the denial directly by the Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-MENANDS, Albany, New York 12241.

4. Additional Appeal Procedures

If, on appeal, the Fund considers, relies upon or generates any new or additional evidence in connection with a claim, this evidence must be provided to you as required by law.

Also, if the Fund denies your claim on a basis other than what is originally stated in your initial claim denial, the Fund will provide this basis to you.

5. External Review of Denied Claims

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

A request for external review must be filed with the Fund Office within 4 months after you receive notice of the adverse benefit determination. The Fund will forward the claim to an IRO for review and the IRO will follow the procedure under the law for reviewing your claim.

Within 5 business days of receiving your external review request, the IRO will complete a preliminary review of your request to determine whether it is eligible for external review. Within 1 business day after the preliminary review is complete, the IRO will advise you of its decision. If your claim is eligible for external review, the IRO will review your claim.

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

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

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

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

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

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

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

SECTION 20 SUBROGATION AND REIMBURSEMENT

Were you or your 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 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 advance your (or your Dependent(s)) benefits based on the understanding that you are required to reimburse the Fund in full from any recovery you or your Dependent(s) may receive, no matter how it is characterized. The Fund advances benefits to you and your Dependent(s) 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(s) are required to notify the Fund within 10 days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within 10 days of the initiation of any lawsuit or settlement negotiations relating to 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(s) receive(s) any benefit payments from the Fund for any Injury or Sickness, and you or your Dependent(s) recover(s) any amount from any third party or parties in connection with such Injury or Sickness, you or your Dependent(s) must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on behalf of your or your Dependent(s) in connection with such Injury or Sickness.

Also, if you or your Dependent(s) 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(s) 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 behalf of you or your Dependent(s). 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(s), including any action against an insurance carrier under any uninsured or underinsured 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(s) 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(s) 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(s), a representative of you or your Dependent(s) (including an attorney), or you or your Dependent's estate 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(s) for the benefit of the Fund until paid to the Fund. You and your Dependent(s) hereby consent(s) and agree(s) 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(s) agree(s) to cooperate with the Fund in reimbursing it for Fund expenses, fees, and costs.

Consistent with the Fund's rights in this section, if you or your Dependent(s) 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(s) 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(s) or a representative of you or your Dependent(s) (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(s), 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(s) 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(s) 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 (*See* Section 19) 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(s) in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your Dependent(s) 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 Personal Injury Protection ("PIP"), medical payment, no-fault, and similar insurance.

Under this provision, you and/or your Dependent(s) 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(s) also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent(s) choose(s) not to pursue the liability of a third party, you or your Dependent(s) 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 immediately. Where you or your Dependent(s) choose(s) 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(s) (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(s) must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in a settlement 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(s) waive(s) 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(s) 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 any and all 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(s) to obtain repayment of the benefits advanced by the Fund, you and/or your Dependent(s) 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(s) 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 Dependent(s) agree to waive any applicable statute of limitations defense available regarding the enforcement of any of the Fund's rights to reimbursement.

Any refusal by you or your Dependent(s) to allow the Fund a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your Dependent's behalf relating to the applicable Injury or Sickness, will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. By accepting benefits under the terms of this Plan, you and your Dependent(s) affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other Plan rule, including but not limited to a statute of limitations defense or preemption defense, to the extent permissible under applicable law. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

This reimbursement and subrogation program is a service to you and your Dependent(s). 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 the costs incurred as a result of your or your Dependent's Injuries.

SECTION 21 RIGHT OF RECOVERY

If the Fund pays benefits in error, such as when the Fund pays you or your Dependent(s) more benefits than you are entitled to, or if the Fund advances benefits that you or your Dependent(s) are required to reimburse because, for example, you have received a third party recovery (*See* Section 20 of this SPD), you are required to reimburse the Fund in full and the Fund has the right to recover any such benefits from you and/or your Dependent(s) or from the service provider that received the payment and any other person covered through the Participant.

Any refusal by you or your Dependent(s) to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent(s) affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a status of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your Dependent(s) refuse(s) to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods which include, but are not necessarily limited to such amount may be deducted from any future benefit payment to which you and/or your Dependent(s) may be entitled from the Fund. If an incorrect payment is made to or on your or your Dependent's behalf, you and your Dependent(s) are both responsible for the overpayment and the Fund has the right to recover any overpayment from either or both of you, or from any other person covered through you.

The Fund shall have a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your Dependent(s), a representative of you or your Dependent(s) (including an attorney), or you or your Dependent's estate 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(s) for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your Dependent(s) consent(s) and agree(s) 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/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent(s) agree(s) to cooperate with the Fund in reimbursing it for the Fund expenses, fees, and costs related to the collection of those benefits.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your Dependent(s) to obtain repayment of the benefits advanced by the Fund, you or your Dependent(s) 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 or your Dependent(s) 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 the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

SECTION 22
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 September 23, 2013

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 and Weekly Disability 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 components under the Plan subject to HIPAA Privacy regulations shall include all the health care components of the Plan, including all medical benefits, prescription drug benefits, dental benefits and optical benefits but shall 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 your 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 your 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. For health records that the Fund keeps in electronic form, you may request to receive the records in an electronic format.

To inspect or to obtain a copy your health record, submit a written request to the Fund's HIPAA Privacy Officer identified below. The Fund may charge a reasonable fee based on the cost for copying and mailing records associated with your request. Records provided in electronic format also may be subject to a small charge. 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 prior to April 14, 2003. To request an accounting of disclosures, submit a written request to the Fund's HIPAA Privacy Officer identified below. In response to your request for an accounting of disclosures, the Fund may provide you with a list of business associates who make such disclosures on behalf of the Fund, along with contact information so that you may request the accounting directly from each business associate.

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. Except in the case of disclosures for payment purposes where you have paid the healthcare provider in full, out of pocket, 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. 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.

Right to Receive Notice of a Breach of Your Protected Health Information

We are required to notify you if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured – for example, computer data that is encrypted and inaccessible without a password.

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
20 North Central Avenue
Valley Stream, N.Y., 11580
(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 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request.

EFFECTIVE DATE

This Notice was first effective on April 14, 2003, and was revised effective February 17, 2010 and September 23, 2013, to reflect the provisions of the Health Information Technology for Economic and Clinical Health ("HITECH") Act. This Notice will remain in effect unless and until the Fund publishes a revised Notice

SECTION 23 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 providing Hospital Benefits, Major Medical Benefits, Life and Accidental Death and Dismemberment Benefits, New York State Weekly Disability Benefits, Optical Benefits, Dental Benefits and Prescription Drug Benefits and other miscellaneous benefits, as well as limited Hospital Benefits and Medical/Surgical Benefits to Retirees.

Plan Sponsor: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580, (718) 845-5800.

Plan Administrator: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580, (718) 845-5800.

Agent for Service or Legal Process: The Board of Trustees of Division 1181 A.T.U. — New York Welfare Fund, 20 North Central Avenue, Valley Stream, N.Y., 11580. 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 and accidental death and dismemberment benefit in Section 11 are provided through a policy of insurance with First Unum Life Insurance Company. These benefits are paid through the insurance contract and First Unum Life Insurance Company provides claims processing services for these benefits.

Source of Contributions: Benefits under the Plan are funded by contributions from Employers that are signatories to collective bargaining agreements with the Union and agreements with the Fund, as well as contributions from Employees. 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 may be obtained from the Plan Administrator.

Collective Bargaining Agreement: 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 are 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 employees to handle 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:

EMPLOYER TRUSTEES

Stanley Brettschneider
2 Winding Brook Drive
Larchmont, N.Y. 10538

Neil Mancuso
Boro Transit, Inc.
50 Snediker Avenue
Brooklyn, N.Y. 11207

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

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

UNION TRUSTEES

Michael Cordiello, Chairman
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, N.Y. 11580

Jean-Claude Calixte
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, N.Y. 11580

James Hedge
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, N.Y. 11580

Thomas Fret
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, N.Y. 11580

Statement of Participant's Rights

As a Participant in the Division 1181 A.T.U. — New York Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge at the Fund Office all documents governing the Plan, including insurance contracts, 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 descriptions upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 for the purpose of preventing 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 you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. However, before you can file suit, you must exhaust your administrative remedies (that is, file an

appeal). 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 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 was 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, 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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