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

RETIREE SUMMARY PLAN DESCRIPTION

Address:
20 North Central Avenue
Valley Stream, NY 11580

Telephone:
(718) 845-5800

® GCC/IBT 243-C

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

RETIREE SUMMARY PLAN DESCRIPTION

Revised as of September 1, 2018

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

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

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GENERAL INTRODUCTION

This document describes the Plan of benefits available to Eligible Retirees under the Division 1181 A.T.U. - New York Welfare Fund under the revised program of benefits, generally effective as of January 1, 2017 ("Plan"). This document is called 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 Eligible Retirees, 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 apply 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 (if you are a Medicare Eligible Retiree) or a customer service representative at Empire Blue Cross Blue Shield ("Empire") (if you are a non-Medicare eligible retiree). The Fund Office address is Division 1181 A.T.U. - New York Welfare Fund, 20 North Central Avenue, Valley Stream, NY, 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, NY 10008. Telephone (866)513-2473. Empire's hours are 9:00 a.m. to 5:00 p.m. EST.

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

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

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

Please remember that no one other than the Fund Office can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the Plan made by anyone else. It is extremely important that you keep the Fund Office informed of any change in address or desired changes in dependents and/or beneficiary. 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 sumario y descripción de Fund ("Summary Plan Description"). Las provisiones de este documento estan sujetas a enmender y interpretar por el "Board of Trustees" (los fideicomisarios) y a las reglas, regulaciones y procedimientos del Plan en efecto al tiempo de reclamo. El "Board of Trustees" (los fideicomisarios) tienen el derecho de interpretar los terminos de este documento y los interpretaran y aplicaran en situaciones no specificamente consigadas en est documento. En caso de conflicto entre los terminos de este sumario y los terminos del Plan, los terminos del Plan dominaran.

Este documento contiene, en Ingles, un sumario de beneficios y derechos en el Division 1181 A.T.U. - New York Welfare Fund que le pertenesen a usted. Si usted tiene dificultad entendiendo cualquier parte de este material, contacte a la oficina del Fondo y Empire. La direccion es Division 1181 A.T.U. - New York Welfare Fund, 20 North Central Avenue, Valley Stream, NY, 11580 Telefono: (718) 845-5800. Horas de oficina son de 8:00 A.M. hasta 4:00 P.M. La dirreccion de Empire es Empire es Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. Telefono (866)513-2473 (9:00 a.m. to 5:00 p.m. EST)

ENTWODIKSYON JENERAL

Dokiman sa a dekri Plan avantaj ki disponib pou Retrete ki ranpli kondisyon yo e ki anba Divizyon 1181 A.T.U. - New York Welfare Fund, nan kad pwogram avantaj yo (yon pwogram revize), ki antre an vigè jeneralman nan dat 1ye janvye 2017 ("Plan"). Dokiman sa a rele "Rezime Deskripsyon Plan"l oswa "SPD" (ann anglè). Konsèy administrasyon an gen dwa pou l entèprete dispozisyon ki anndan dokiman sa a, pou l aplike l, pou l fè yon pase men adan l e pou l pran desizyon ki baze sou reyalite anrapò ak mete dispozisyon sa yo anplas, entèprete yo epi aplike yo. Nenpòt desizyon konsèy administrasyon an pran ak tout bon entansyon l aplike sou Retrete ki ranpli kondisyon yo, sou fanmi yo ak tout lòt moun Plan an konsène.

Dokiman sa a se yon deskripsyon dwa ak avantaj ann anglè ki aplike sou ou anba divizyon 1181 A.T.U. - New York Welfare Fund. Si w gen pwoblèm pou w konprann nenpòt pati ki nan materyèl sa a, ou dwe pran kontak ak Biwo Trezò a, anpalan de "Fund Office", si w se yon retrete ki ranpli kondisyon pou w benefisye swen medikal (Medicare). Yon lòt bò, ou ka kontakte yon reprezantan sèvis kliyantèl la nan Empire Blue Cross Blue Shield (oswa Empire) si w pa yon retrete ki ranpli kondisyon pou w benefisye swen medikal (Medicare). Men adrès Biwo Trezò a (oswa Fund Office la): "Division 1181 A.T.U. - New York Welfare Fund, 20 North Central Avenue, Valley Stream, NY, 11580. Telefòn nan se (718) 845-5800. Biwo Trezò a ouvri soti 8 è nan maten pou rive 4 è nan aprèmidi. Adrès Empire la se:Empire Blue Cross Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008. Nimewo telefòn nan se (866) 513-2473. Empire ouvri soti 8 è nan maten pou rive 4 è nan aprèmidi Lè nou sèvi se lè EST (Eastern Standard Time).

Notice of Grandfathered Status for Medicare Eligible Retiree Benefit Program Only

The Division 1181 A.T.U. – New York Welfare Fund believes that its benefit program for Medicare Eligible Retirees is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your benefit program may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, effective January 1, 2011,

grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

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

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SECTION 1
DEFINITIONS

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

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

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

Chiropractor means a 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 an Eligible Retiree and his or her Dependent(s).

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

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, 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 Eligible Retiree must provide the Fund Office 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. **Dependents with Disabilities.** Any Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability, may be a Dependent under the Plan, provided such child suffered the incapacity prior to reaching age 19 and is dependent upon you for support and maintenance. In such circumstances, you must submit a comprehensive medical report including 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. If your claim for extension of coverage because of disability is denied based on a determination by the Fund, the Fund will provide you with notifications in a denial letter, including any appeal denial letter, as required by law for disability claims.

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

E. **Coordination Between Non-Medicare Eligible and Medicare Eligible Retiree Coverage for Dependents**. Even if an Eligible Retiree attains age 65 or becomes Medicare-eligible, his or her Spouse remains entitled to Non-Medicare Eligible Retiree coverage until the Spouse attains age 65 or becomes Medicare-eligible. Likewise, an Eligible Retiree's Dependent children continue to be covered under Non-Medicare Eligible Retiree coverage until the Dependent child becomes Medicare-eligible or no longer meets the definition of Dependent under this Plan.

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

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

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

Employer means any employer that agrees to be bound by the terms of the Trust Agreement 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 Transit Federal 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 or ***Investigative*** A drug, device, medical treatment, or procedure is considered experimental or investigative unless:

A. The approval of the U.S. Food and Drug Administration and approval for marketing the drug or device for the particular purpose being requested has been given at the time the drug or device is furnished;

B. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;

C. Reliable Evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

D. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, it 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 by 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 treatment that is required to identify or treat the Sickness or Injury that a Physician or Dentist or other provider of health care has diagnosed or reasonably suspects. The service must be: (A) consistent with currently accepted medical practice and with the diagnosis and treatment of the condition; (B) in accordance with local standards of good medical practice; (C) required for reasons other than the person's or the health care provider's convenience; (D) performed in the least costly setting required by your condition; and (E) not Experimental in nature.

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

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

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

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

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

Room and Board means all charges commonly made by a Hospital on its own behalf for a room and meals and for general services and activities essential to the care of 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 Amalgamated Transit Union A.F.L. - C.I.O. Local 1181-1061.

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

SECTION 2
ELIGIBILITY FOR BENEFITS

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

I. ELIGIBILITY OF RETIREES

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

1. you were employed at the time of your termination of Employment by an Employer contributing to this Fund and/or any welfare funds that later merged into this Fund or contributing to the Cerebral Palsy Associations of New York State, Inc. 403(b) Pension Plan ("CPT Plan"); and

2. (a) you were eligible to receive a pension benefit from the Division 1181 A.T.U. – New York Employees Pension Fund, the Command – Local 1181 Pension Fund at the time of your termination of Employment based on 10 years of credited service with the Fund; Or

   (b) you were eligible to receive a pension benefit under the CPT Plan at the time of your termination of Employment under the CPT Plan after (1) having attained the age of 55 and having earned 10 years of service, or (2) having earned at least 25 years of service, regardless of your age.

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

You must actually submit your papers to retire within 60 days of terminating Employment. If you delay in the filing of your retirement, you may sacrifice your right to receive your

Retiree Benefits and may have to appeal to the Board of Trustees to request reconsideration. However, if you work in Employment in June, you will have until September 30th of that Plan Year to elect to receive Retiree Benefits. If you elect Retiree Benefits, your coverage will be effective the first day of the month following your election of Retiree Benefits.

If you are out on worker's compensation leave and remain on the Master Seniority List, even if you are no longer in Employment and not covered under the Active Plan, you still have 60 days to elect Retiree Benefits from the date that is the earlier of (1) the one-year anniversary of when you began your worker's compensation leave or (2) the date you are removed from the Master Seniority List, for whatever reason.

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

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

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

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

II. ELIGIBILITY OF DEPENDENTS

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

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

You may add or remove a Dependent from enrollment at any time. To add or remove a Dependent, you must request the change in writing that must state when you want the removal to be effective and you must submit a new enrollment card. You must also provide the Social Security Number of the Dependent to be added or removed and documentation

to support the change such as proof of marriage, birth, adoption, guardianship, or foster care placement, to add a Spouse or child as a Dependent, proof of disability to extend a child's coverage, or proof of divorce, death or end of dependency to remove a Dependent.

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

III. MONTHLY CO-PREMIUM

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

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

IV. ANNUAL OUT-OF-POCKET MAXIMUMS

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

SECTION 3
TERMINATION OF COVERAGE

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

Coverage for Dependents terminates on the earlier of (1) your death or (2) the date the individual no longer meets the definition of Dependent (for example, the date you and your Spouse are legally separated, or when a Dependent child attains age 26). See Section 9 for information regarding your Dependent's right to COBRA Continuation Coverage.

SECTION 4
BENEFITS PROVIDED

This Section explains the benefits that apply to Eligible Retirees and Dependents who are entitled to Retiree Benefits as stated below. The benefits provided under this Retiree Plan are different for non-Medicare eligible Retirees and their Dependents and Medicare Eligible Retirees and their Dependents, except where noted.

I. LIFE INSURANCE.

This benefit applies to both non-Medicare eligible and Medicare eligible Retirees. The Fund has a contract with The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004 for life insurance benefits. These benefits are paid through the insurance contract and the insurance company provides claim processing services for these benefits. Through this insurance, the Fund provides $9,000 in life insurance benefits to Eligible Retirees. It does not apply to Dependents.

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.

II. HOSPITAL/MAJOR MEDICAL BENEFITS FOR NON-MEDICARE ELIGIBLE RETIREES.

The Hospital and Medical Benefits provided to Non-Medicare Eligible Retirees and their Dependents are the same as the Hospital Benefits provided to Eligible Employees under the Active Plan and are described in detail below. Once an Eligible Retiree and/or their Dependents becomes eligible for Medicare, this Plan pays as secondary. Please refer to subsection III of this Section for details on Hospital and Major Medical Benefits provided to Medicare Eligible Retirees and their Dependents.

HOSPITAL BENEFITS FOR NON-MEDICARE ELIGIBLE RETIREES

The Fund provides the following Hospital Benefits to each Non-Medicare Eligible Retiree and their Dependents.

The Fund has arranged with Empire, for you and your Dependents, a network of preferred Hospitals from which to choose. Because Empire participating 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.

A. IN-PATIENT SERVICES

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

1. Room and Board. The Fund will cover up to 120 days of Room and Board.

The Fund will cover up to 120 days of Room and Board during a single hospitalization or during several separate hospitalizations, as long as there are fewer than 90 days between admissions. If there 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 medications for use in the Hospital, including radium or radioactive substances, which are commercially available for purchase and readily obtainable by the Hospital;

f. Blood, blood storage, use of blood transfusion equipment and administration of blood or blood derivatives when given by a Hospital employee;

g. Oxygen and use of equipment for its administration;

h. Anesthesia supplies and use of anesthesia equipment;

i. Dressings and plaster casts;

j. Use of cardiographic equipment;

k. Physiotherapeutic and hydrotherapeutic treatments when administered by a Hospital employee;

l. Hospital confinement or any period of Hospital confinement primarily for rehabilitation for up to 20 days per calendar year. Rehabilitation Services are covered only when provided in accredited units, as an extension of a hospitalization for an accident or Disability, and when a patient with a Disability has a clear potential for functional improvement;

m. Charges for radiation therapy and/or chemotherapy; and

n. Out-patient diagnostic testing.

3. Maternity Care.

Maternity benefits are provided for expenses incurred in a Hospital by an Eligible Retiree or an Eligible Retiree's Spouse. Except to the extent required by law, maternity benefits are not payable for the pregnancy of a Dependent child.

Hospital benefits will be provided for Hospital confinements arising from any pregnancy related condition, whether or not pregnancy is terminated. Additionally, Hospital benefits for routine nursery care of the newborn child or newly-born child adopted or placed for adoption with an Eligible Retiree 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 Dependent child 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. Co-payment for Non-Empire Facility

There is a $500 co-payment for all elective admissions and ambulatory procedures performed in a facility that is 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 Eligible Retirees 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 co-payment for in-network emergency room services, which will be waived if you are admitted to the Hospital.

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;

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 all non-Preferred Providers, you are 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 a preliminary 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.

Benefits for Covered Home Health Care services are as follows:

1. If Covered Home Health Care services are rendered by a Home Health Care Agency and begins within 7 days of discharge from a Hospital, full coverage will be provided for a maximum of 200 home care visits per calendar year.

2. If Covered Home Health Care services are rendered without prior confinement to a Hospital or through an agency that is not a Home Health Care Agency under the Plan's definition, there will be a $50 cash deductible, and the Fund will pay 75% of the Agency's charge, up to the Allowable Charge, for a maximum of 40 home care visits per calendar year.

3. Covered Home Health Care services include: part-time professional nursing; part-time home health aide services (4 hours of such care is equal to one home care visit); physical, occupational or speech therapy; medical supplies, drugs and medications 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 to the Hospital for needed care.

D. SKILLED NURSING FACILITY

The Fund will allow up to 30 days per calendar year for care at a skilled nursing facility, if facility admission is determined to be Medically Necessary through the Empire pre-authorization and discharge planning process. This 30-day limited benefit is allowed for Eligible Retirees and Dependents 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.

E. 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 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.

2. Dialysis for Kidney Failure.

Hospital benefits are provided for hemodialysis or peritoneal dialysis while you or your Dependent is a registered in-patient in a Hospital.
Hospital benefits are also provided for out-patient dialysis, as follows:

a. For dialysis at home, the Fund will pay the cost of all appropriate and necessary supplies as well as the Allowable Charge for rental cost of the required equipment and the attending nurse.

b. For dialysis at a Hospital or freestanding facility, the Fund will pay the cost of treatment of the Hospital's or facility's dialysis program.

F. HOSPICE CARE

You and your 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 which are considered approved under the U.S. Pharmacopoeia and/or National Formulary; (not covered when the drug or medication is of an Experimental nature);

k. Medical care provided by the hospice Physician;

l. Five visits for bereavement counseling for the Covered Person's family either before or after the Covered Person's death;

m. Durable medical equipment provided prior Fund approval is obtained;

n. Transportation between home and Hospital or hospice organization provided such transportation is Medically Necessary.

G. WORLDWIDE PROTECTION

Hospital benefits cover services rendered anywhere in the world. Elective treatment outside of the United States requires prior Fund approval. Please contact the Fund Office for more information.

H. ORGAN TRANSPLANTS

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

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.

I. LARGE CLAIM SETTLEMENT PROGRAM

The Board has implemented a large claim settlement program. In the sole discretion of the Board of Trustees, based on the Fund's financial circumstances, the Board may designate an amount to be used to attempt, through negotiated settlements, to resolve claims 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, 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 Direct Plus ID Card to the Hospital admitting clerk. Hospital bills will be sent from the Hospital to Empire and will be paid directly to the Hospital. Pre-certification is required for in-patient and ambulatory services.

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

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

MAJOR MEDICAL BENEFITS FOR NON-MEDICARE ELIGIBLE RETIREES

Major Medical benefits are payable for Non-Medicare Eligible Retirees and their Dependents and 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 a Preferred Provider, generally you only pay the co-payment, if any, to receive treatment for services covered by the Plan, except as otherwise provided in this Plan. Pre-certification is not required for office visits.

-- If you do not use a 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 a 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 a Preferred Provider.

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

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 co-payment is $25 for each office visit with a primary care Physician and $40 for each office visit with a specialist. However, if Limited Covered Medical Expenses are used, 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 network. The directory lists Physicians according to location and type of practice.

2. Select a Preferred Provider and schedule an appointment. Verify that he or she is still participating in the network.

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 facility visits.

4. The Fund's contract with Empire covers certain preferred labs and diagnostic services. Show your Empire ID Card. There is a $25 copayment for in-network labs and diagnostic services. Using an Empire facility can save you money because the Empire facilities will accept payment by the Fund as full payment. Your Empire directory lists the locations where you can have tests done.

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

B. 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 BlueCross/Blue Shield negotiates lower fees

with its Preferred Providers, 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 network, you likely will have to pay much more of the bill if you use a non-Preferred Provider.

The following services and supplies are covered major medical expenses:

1. Charges by a Physician for medical care, treatment and surgery. In the event of surgery, some medical care by the surgeon may not be covered since the Fund's Allowable Charge may only include 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;

    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 are allowed, up to a limit of 36 visits per calendar year, if approved by the Fund in advance.

7. Charges for out-patient speech therapy rendered by a licensed therapist if referred by the Covered Person's Physician and approved in advance by the Fund. If the purpose of the therapy is articulation, the Fund will only cover it if the deficiency is congenital in nature. 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. Ambulettes are not covered. Air ambulances are also covered if the Fund determines that the conditions for requiring air ambulance transport are met. If these conditions are not met, but the Eligible Retiree and/or Dependent's condition did require transportation via a land ambulance, the Fund's coverage will be limited to the amount the Fund would have paid for a land ambulance.

9. Charges by a Dentist for treatment of natural teeth due to accident, provided that treatment to natural teeth must be completed within 12 months of the accident for the services to be covered.

10. Rental (up to the purchase price) or purchase (if less expensive) of custom-made prosthetics, wheelchairs and other durable medical equipment and supplies for treatment of a specific Sickness or Injury, provided prior approval by the Fund is obtained.

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 4(F) 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. PREVENTIVE CARE SERVICES

As required by law, the Fund covers a number of preventive services without any Plan cost-sharing for you and your Dependents, such as physical exams, screenings, tests, vaccines, and other preventive services 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 service. If you have any questions about whether a particular exam screening, test or vaccine is covered, please contact Empire at 1 (866) 513-2473.

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

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

If both Spouses are Participants (i.e., you are an Eligible Retiree 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. The following charges for podiatric services are not covered:

    a. Routine care or treatment of conditions for the feet such as corns, bunions (except capsular or bone surgery), callouses, removal of nails of the feet (except the removal of the entire nail), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This limit on podiatric services does not apply to Covered Persons whose treatment arises from diabetes;

    b. Orthotics;

    c. Casting, fabrication, and dispensing of orthotics;

    d. Dispensing of surgical shoes. Jobst stockings are covered up to 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

    i. Injection of local anesthetic

    j. Diagnostic tests performed or ordered by a Podiatrist are not covered, except for X-rays. X-rays ordered by a Podiatrist are Covered Limited Medical Expenses.

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

F. DIABETIC PROGRAM

Edge Park provides a diabetic program for Eligible Retirees and Dependents, 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 EST, and Saturday during the hours of 9:00AM and 3:00PM EST.

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 EST.

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 EST, and Minimed can be reached at (800) 933-3322, Monday through Friday during the hours of 8:00AM and 6:00PM Central Time.

G. DENIAL OR LOSS OF BENEFITS

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

1. In-patient or out-patient facility charges (may be covered under Hospital benefits).

2. Charges for dental work or treatment, except biopsies.

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.

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

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

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 medications.

13. Charges for membership fees, dues or any other charges in connection with recreational facilities, fitness, diet, stress management or nutritional centers, even if prescribed or recommended by a Physician.

14. Charges for facility fees (e.g. abortion clinics, surgical centers) (may be covered by Hospital Benefits).

15. Charges for treatment of sexual dysfunction not related to organic disease.

16. Charges for Home Health Care services and expenses for services performed by L.P.N.s, nurses aides, home health care aides, companions, or housekeepers) (may be covered under Hospital Benefits).

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.

III. HOSPITAL AND MEDICAL BENEFITS FOR MEDICARE ELIGIBLE RETIREES

Hospital Benefits and Medicare

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

In order to qualify under the Plan for co-payment and deductible benefit amounts, you must apply for and be enrolled in both Part A and Part B of Medicare.

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

A. IN-PATIENT SERVICES

1. Room and Board. The Fund will cover up to 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 is more than 90 days between admissions, a new 120-day period will begin with the next hospitalization. After you have used the 120 days of Room and Board, there must be at least a 90 day period of separation between hospitalizations before another period of hospitalization will be covered. However, the Fund will not be responsible for any day of hospitalization that is not covered by Medicare as the primary payor.

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 medications for use in the Hospital, including radium or radioactive substances, which are commercially available for purchase and readily obtainable by the Hospital;

    f. Blood, blood storage, use of blood transfusion equipment and administration of blood or blood derivatives when given by a Hospital employee;

    g. Oxygen and use of equipment for its administration;

    h. Anesthesia supplies and use of anesthesia equipment;

    i. Dressings and plaster casts;

    j. Use of cardiographic equipment;

    k. Physiotherapeutic and hydrotherapeutic treatments when administered by a Hospital employee;

    l. Charges for radiation therapy and/or chemotherapy; and

    m. Out-patient diagnostic testing.

B. OUT-PATIENT SERVICES

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

1. **Emergency Treatment and/or Ambulatory Surgery**.

a. Emergency first aid during the first visit for treatment of an accidental Injury;

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.

2. Presurgical Testing.

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

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

C. SPECIAL CONDITIONS

1. Mental or Nervous Disorders.

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

2. Dialysis for Kidney Failure.

Hospital benefits are provided for hemodialysis or peritoneal dialysis while you or your Dependent is a 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.

D. 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.

E. ORGAN TRANSPLANTS

Where the organ transplant procedures are determined by the Fund 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.

OTHER MEDICAL BENEFITS FOR MEDICARE ELIGIBLE RETIREES

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

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

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

1. Charges by a Physician for medical care, treatment and surgery. In the event of surgery, some medical care by the surgeon may not be covered since the Plan's Allowable Charge may only include certain pre-operative and post-operative care.

2. Surgical procedures performed at one time through the same incision are considered one surgical procedure. Payment is made for the procedure with the highest Allowable Charge at 100%, a second procedure paid at 50% of the Allowable Charge and the third and fourth procedure paid at 25% of the Allowable Charge. When a procedure code is submitted that is part of another major procedure code, only the major procedure code is reimbursed.

3. Charges by a Physician (other than the surgeon) for administration of anesthesia.

4. Charges for the following diagnostic tests (which are provided by the Fund at no out-of-pocket cost):

    a. X-ray and laboratory;

    b. Computerized Axial Tomography ("CAT scans");

    c. Magnetic Resonant Imaging ("MRI");

    d. Electromyography ("EMG");

    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;

    j. Cardiology.

5. Charges for the taking and interpreting of diagnostic procedures. If separate claims are submitted for the technical and professional component of one diagnostic procedure, the Fund allows 60% of the Allowable Charge for the technical component of the procedure and allows 40% of the Allowable Charge for the professional component, and then pays 80% of the Allowable Charge for each component.

6. Charges for outpatient rehabilitation (physical therapy) by a licensed therapist under direction of a Physician up to 4 visits per calendar year.

7. Charges for blood transfusions by a Physician and the storage of blood or blood plasma.

8. Charges for cardio rehabilitation on an outpatient basis, up to a maximum of 90 visits per calendar year.

9. Charges for radiation therapy and/or chemotherapy.

10. Services rendered by a Physician for acupuncture.

11. Charges for Physician services associated with kidney dialysis.

12. If the Covered Person is receiving benefits in connection with a mastectomy, charges for: (a) reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

13. Charges for allergy treatments up to 16 visits per calendar year.

14. Charges for a well woman visit: with a condition – one per calendar year; without a condition – one every two years (per Medicare Guidelines)

LIMITATIONS AND EXCLUSIONS FOR MEDICARE ELIGIBLE MEDICAL BENEFITS

In addition to the exclusions applicable to all forms of benefits under the Plan in Section 5, Hospital and Medical benefits will not be paid for Medicare Eligible Retirees and their Medicare Eligible Dependents for the following:

1. Charges for durable medical equipment ("DME") and supplies.
2. Charges for skilled nursing facility and home care.
3. Charges for diabetic supplies – Including diabetic shoes or Una Boot.
4. Charges for ambulance services and air ambulance.
5. Charges for consultation fee by a physician who acts as the surgeon.
6. Charges for chiropractic services.
7. Charges for injections (except for bursa or joint injections).
8. Charges for Assistant Surgeons (except for open heart surgery).
9. Charges for standby Physicians at surgery including Cardiologists, Surgeons, Internists.
10. Charges for standby anesthesiologists.
11. Charges for in-patient private duty nursing.
12. Charges for prescription drugs and non-prescription drugs.
13. Charges for eye examinations, eyeglasses or contact lenses, treatment of myopia and other errors of refraction (including keratoplasty services); orthoptics or visual training; and the fitting or placing of eyeglasses or contact lenses.
14. Charges for urinalysis measurement.
15. Charges for venipuncture.
16. Charges for confinement in a Hospital, medical center or similar facility, or for any program or out-patient care for substance abuse.
17. Charges for sleep disorder testing machine.
18. Charges for annual physical health check-ups.
19. Charges for hearing aids.
20. Charges for immunizations, except for influenza vaccine for Covered Persons with hypertension, diabetes or cancer.
21. Charges of inpatient rehabilitation services.

22. Charges for vitamin therapy or food supplements or dieticians.

23. Charges for membership fees, dues or any other charges in connection with recreational facilities, fitness, diet, stress management or nutritional centers, even though prescribed or recommended by a Physician.

24. Charges for treatment of sexual dysfunction not related to organic disease.

25. Charges in connection with organ transplants if the procedure has not been approved by the Fund.

IV. MEDICARE PART D REIMBURSEMENTS (FOR MEDICARE ELIGIBLE RETIREES AND MEDICARE ELIGIBLE SPOUSES/DEPENDENTS ONLY)

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

SECTION 5
EXCLUSIONS AND LIMITATIONS

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

No benefits will be paid by the Fund for:

A. Any charge, or part of a charge, for which mandatory automobile no-fault benefits are recovered or recoverable, including instances in which coverage is denied by the no-fault carrier if, for example, (1) you or your Dependent are injured while operating a motor vehicle in an intoxicated condition, (2) for charges for a No-Fault Insurance deductible, (3) for charges incurred if you are injured as a passenger in an uninsured vehicle.

B. Charges in connection with a Sickness or Injury that was deliberately self-inflicted, including any suicide attempts or threats.

C. Charges resulting from you or your Dependent's participation in an illegal, criminal or violent act, a domestic dispute or while in police custody. However, injuries resulting from an act of domestic violence or from a medical condition, including mental health conditions, are not excluded solely because the source of the injury was an act of domestic violence or a medical condition.

D. Charges for any Sickness or Injury resulting directly or indirectly from your intoxication due to a drug, narcotic or any other intoxicant.

E. Services that are not Medically Necessary.

F. Elective cosmetic surgery, except for reconstructive surgery that is part of an operation to treat an infection, injury or a disease, or that follows such an operation.

This exclusion does not apply, in connection with a mastectomy, to reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

G. (1) Services usually provided without charge, (2) charges that would not have been made if coverage had not existed, (3) any charges that you or your Dependent is not required to pay, or (4) for which a claim is not filed within the deadline specified in Section 12 (C).

H. Charges paid for by any other person or entity.

I. To the extent allowed by law, any claim for services provided by a Veterans Administration, Federal, State or any other Hospital operated by a governmental unit, unless a charge is made that the Covered Person is legally required to pay without regard to the existence of coverage.

J. Charges for any services rendered by the claimant's Immediate Family.

K. Charges for Experimental or obsolete procedures or drugs.

L. Charges for services if you or your Dependent were not eligible for benefits at the time the claim was incurred.

M. Charges for services if you or your Dependent failed to submit required evidence to support the claim.

N. Charges for services if you or your Dependent made material misstatements in connection with eligibility or the claim.

O. Charges for services if you or your Dependent omitted facts or material statements as to other coverage available to you.

P. Charges for services provided to you or your 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 14.

SECTION 6
SUSPENSION OF BENEFITS

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

SECTION 7
COORDINATION OF BENEFITS

This provision is intended to prevent the Fund from duplicating payments that you may be entitled to under other plans or insurance policies. When you or any of your Dependents are eligible to receive benefits under any other health plan, benefits provided under

Division 1181 A.T.U.-New York Welfare 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 not other plans involved.** All benefits provided by the Plan (excluding life insurance) 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 FOR 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, former employee, or retiree under one health plan and are covered as a dependent under the other health plan, then the health plan covering you based on your employment is primary and the plan covering you as a dependent is secondary.**

Examples of Rule 2 are as follows:

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

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

For your Spouse: The Fund's Active Plan Employee coverage is primary and your retiree dependent coverage is secondary.

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

For you: Medicare is primary and your retiree coverage is secondary;
For your Spouse: This Plan's Dependent retiree coverage is primary.

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

For you: Your primary coverage is Medicare, this Plan's retiree coverage is secondary; and
For your Spouse: Your Spouse's primary coverage is the other retiree health plan, Medicare is secondary, and your retiree dependent coverage pays third.

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

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

If you are an Eligible Retiree with retiree coverage under another health plan (not Medicare eligible):
For you: The retiree plan under which you were covered the longest period of time is primary, the other retiree coverage is secondary.

If you are an Eligible Retiree with other retiree coverage, e.g. NYC, and Medicare:
For you: Medicare is primary, the retiree plan under which you were covered the longest period of time is secondary, and the other retiree health plan pays third.

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

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

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

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

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

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

b. If financial responsibility has not been legally established, then the health plan that covers the child 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 apply, then the plan under which the patient has been enrolled the longest is primary.

7. The Plan will pay only in accordance with these rules and the rules of other health Plan(s) will not change the order in which this Plan will pay.

8. If a Dependent has other coverage such as H.I.P., HMO or any other managed care group using panel Physicians, and chooses not to use the coverage, no Plan benefits will be paid. If the Fund is the secondary payor and the primary payor is a health maintenance organization or preferred provider organization, then the Fund assumes that the primary payor pays the full value of the services and the Fund is secondary only for any deductible or 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 their coordination of benefit rules.

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

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

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

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

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

this Plan will pay the difference between what the other health plan has paid and 100% of the Allowable Charge under this Plan for the claim.

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

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

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

To ensure that the Fund coordinates benefits with any other health plan coverage you have, you must 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 8
COORDINATION OF BENEFITS WITH MEDICARE

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

SECTION 9
COBRA CONTINUATION COVERAGE

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

Qualifying Events

Your Dependents have the right to elect COBRA Continuation Coverage for Retiree Benefits for the following Qualifying Events if it results in the loss of Dependent Retiree Benefits: death of the Eligible Retiree, legal separation or divorce from the Eligible Retiree, a Dependent ceasing to be a Dependent under the terms of the Plan. Loss of coverage due to failure to pay the copayment is not a Qualifying Event.

Reporting Requirements

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

1. Divorce or legal separation of the Retiree from the Dependent Spouse; or

2. A Dependent ceasing to be a Dependent under the terms of the Plan; or

3. The death of the Retiree.

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

Notices should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, at the following address: Division 1181 A.T.U. - New York Welfare Fund, 20 North Central Avenue, Valley Stream, NY, 11580. Written notice of a qualifying event must include the following information: name and address of the Eligible Retiree and Dependent, Retiree's Social Security number, and date of occurrence of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of the divorce decree, separation agreement, death certificate, Dependent's birth certificate). Once the Fund receives timely notification that a qualifying event has occurred, COBRA coverage will be offered to Dependents, as applicable.

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

Financial Responsibility for Failure to Give Notice

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

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

Notice and Election Form

Empire will, within 14 days of receiving notification of a Qualifying Event, send to the Dependent a COBRA Notice and Election Form. This form will describe the coverage available, the cost, and the conditions under which the Continuation Coverage will terminate. In order to obtain COBRA Continuation Coverage, the Notice and Election Form must be completed and returned to Empire or the Fund Office within 60 days of receipt. Payment of the COBRA premium, 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.

Coverage may be continued for any Dependent who is properly enrolled on the day before the Qualifying Event resulting in loss of eligibility (listed above). Each Dependent who is

not a minor has the independent right to elect or reject COBRA continuation coverage. The Eligible Retiree may elect coverage on behalf of his or her Spouse and family members. An election on behalf of a Dependent child can be made by the child's parent or legal guardian.

Details of Continuation Coverage

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

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

Payment Provisions

Under COBRA, you will have to pay the cost for your Continuation Coverage. Continuation Coverage requires timely application for coverage and timely monthly payments. The payment due date is the first day of the month in which COBRA Continuation Coverage begins. For example, payments for the month of November must be paid on or before November 1st. The Payment due for the initial period of COBRA Continuation Coverage must include payment for the period of time dating back to the date that coverage would have terminated if your Dependent(s) had not elected COBRA Continuation Coverage. If your Dependent fails to pay the full payment by each due date (or within the 30 day grace period), he or she will lose all COBRA Continuation Coverage. Payments due under COBRA coverage must be made to the following address: Empire Blue Cross Blue Shield, P.O. Box 660212, Dallas, TX 75266.

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

Cost of COBRA Coverage

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

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

Continuation Period

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

Termination of COBRA Coverage

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

1. The date that the Fund terminates or no longer provides Retiree Benefits to similarly situated Dependents;

2. The date that the Dependent does not pay the premium due in full by the end of the grace period;

3. The date that the Dependent becomes covered under another group health plan (as an employee or otherwise), as long as such date is after the qualifying event. Contact the Fund for additional information when your Dependent becomes covered under another group plan.

4. The date that the Dependent first becomes eligible for Medicare, as long as such date is after the qualifying event.

5. The date that the applicable period of COBRA Continuation Coverage ends.

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

Trade Act Rights

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

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.

Contact for Additional Information

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

SECTION 10
CERTIFICATE OF CREDITABLE COVERAGE

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

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 11
QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

The Fund will also provide Dependent coverage for a child that is placed for adoption with you regardless of whether the adoption is finalized. A child will be considered placed for adoption with you if you assume a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with you will be considered terminated when you no longer have a legal obligation to support the child. You will be required to supply evidence to the Fund that a child placed for adoption with you for whom Dependent coverage is requested has actually been placed with you for adoption.

SECTION 12
GENERAL CLAIMS PROCEDURES

A. For Non-Medicare Eligible Retirees:

IF YOU NEED TO FILE A HOSPITAL OR MEDICAL CLAIM

Empire makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from Preferred 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-Preferred 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.

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 1-866-513-2473 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 payor, submit the original or a copy of the primary payor's EOB with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

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

B. For Medicare Eligible Retirees

HOW TO CLAIM BENEFITS:

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

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

TO FILE A CLAIM:

Most healthcare claim Providers for Medicare recipients will send their Hospital/Medical, Part A and Part B charges to Medicare first for processing electronically. Once the claims are processed, C & R Consulting will electronically retrieve Medicare adjudicated claims through an electronic crossover system.

If for some reason a claim is not submitted to Medicare first, such as Medicare Advantage type program, then the Universal HCFA 1500 Form needs to be completed by the Provider in the appropriate part of the claim, and must be signed by you, and attach the Providers itemized statement of charges if this information is not on the claim form. If the Patient has other insurance coverage, you must attach the Explanation of Benefits, or the Medicare Explanation of Benefits statement, whichever is applicable.

You should sign Item 12, Authorization to Release Information, and Item #13, Authorization to be Paid, if you wish the benefit to be paid directly to the Provider. The completed form and all documents should then be forwarded to C & R Consulting.

C. Claims Filing Deadline

If you are a Non-Medicare Eligible Retiree, all claims for you and your Dependents must be received by Empire no later than 12 months from the date in which services were rendered. For example, claim forms for services rendered on July 1, 2016 must be received no later than July 1, 2017. FILE YOUR CLAIM AS SOON AS POSSIBLE.

If you are a Medicare Eligible Retiree, all claims for you and your Dependents must be received by C&R Consulting no later than 12 months from the date the provider submits the claim to Medicare.

SECTION 13
CLAIM DENIALS

I. GENERAL PROCEDURES

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

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

For non-Medicare Eligible Retirees, Empire is charged with the processing of hospital and medical claims under the Plan on the Fund's behalf. For Medicare Eligible Retirees, C&R

Consulting is responsible for processing all hospital and medical claims. Appeals for all benefits will be handled by the Fund. Please note that even where the foregoing section refers to the Fund, the aforementioned entities will be responsible for processing claims and appeals within the appropriate time limits set forth below. The Fund's procedures and time limits for processing medical claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Life Insurance benefits under the Fund are provided pursuant to an insurance contract between the Fund and Guardian Life Insurance Company. For a description of the procedures that you must follow in order to submit a Life Insurance claim and the procedures you must follow in order to appeal the denial of a Life Insurance claim, please refer to your Guardian Life certificate of insurance or contact Guardian Life at 7 Hanover Square, New York, NY 10004.

II. INITIAL CLAIM REVIEW

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

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

If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within 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 a 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 re-file the claim, the Fund will have to decide the claim based on the information it has available, and your claim may be denied.

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

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the Fund will notify you of the decision (whether approved or denied) within 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 set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice to provide the requested information. If you do not provide the information requested, the Fund will decide the claim based on the information it has available, and your claim may be denied.

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

For Non-Medicare Eligible Retiree and their Dependents only, the Fund will provide, upon request, the diagnosis codes, treatment codes and their meaning in connection with any adverse benefit determination made by the Fund. **However, making this request is not an appeal; see the appeal procedures that follow on how to appeal an adverse benefit determination.** If you are a Non-Medicare Eligible Retiree and 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.

III. APPEAL PROCEDURES

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees. Your appeal must be in writing and must be sent to the Board of Trustees at the address shown on page 56. An appeal of an Urgent Care claim (see above) may also be made by telephone by calling Empire at (866) 513-2473.

If your claim for 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 treat the Fund's initial decision as correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary or appropriate), the Board of

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

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of Trustees, through Empire or C&R Consulting, 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.

For appeals submitted by Non-Medicare Eligible Retirees and their Dependents, if the Fund relies upon, considers or prepares new or additional evidence in connection with a claim, this evidence will be provided to you as required 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 and give you a chance to respond before a final decision is made on appeal.

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 17 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 also 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 Plan 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.

IV. External Review of Denied Claims (For Non-Medicare Eligible Retiree Claims Only)

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

A request for external review must be filed with the Fund Office within 4 months after you receive notice of the adverse benefit determination. The Fund will forward the claim to the 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 reason for the external review request, including information sufficient to identify the claim (such as date(s) of service, the health care provider, the claim amount (if applicable)), the reason for the previous denial and other information required by law.

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

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

2. *Expedited External Review.*

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

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

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

SECTION 14
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 expenses, and these expenses would not be covered under the Fund.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay you (or your Dependent) 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 arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

If you or your Dependent(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 you or your Dependent(s) in connection with such Injury or Sickness.

Also, if you or your Dependent receive any benefit payments from the Fund for any Injury or Sickness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your Dependent's name and also has a right to intervene in any such action brought by you or your Dependent(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) or 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 and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent(s) agree to cooperate with the Fund in reimbursing it for Fund expenses, fees, and costs. The Fund's constructive trust, lien and/or an equitable lien by agreement in favor of the Fund also applies to any amount received by you or your Dependent's estate that is due to the Fund under this Section.

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 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 chooses 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 Blue Cross Blue Shield immediately. Where you or your eligible Dependent(s) choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent(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. 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) waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent(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 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 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 for your injuries.

SECTION 15
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 14 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 Eligible Retiree/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 statute 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, the 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(s) 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 16
NOTICE OF PRIVACY PRACTICES

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

Effective Date of Notice 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 17
OTHER IMPORTANT INFORMATION

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

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

Employer Identification Number: 23-7255573

Plan Number: 503

Plan Year and Fiscal Year: January 1 to December 31

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

Plan Sponsor: The Board of Trustees of Division 1181 A.T.U. - New York Welfare Fund, 20 North Central Avenue, Valley Stream, NY, 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, NY, 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, NY, 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 benefit is provided through a policy of insurance with Guardian Life Insurance Company. This benefit is paid through the insurance contract and Guardian Life Insurance Company provides claims processing services for these benefits.

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

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

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

Type of Administration: The Board of Trustees is the Plan Administrator. The Board of Trustees employs Empire Blue Cross Blue Shield to provide claims processing and other related administrative services for non-Medicare Eligible Retirees and C&R Consulting to provide claims processing services for Medicare Eligible Retirees. The Board of Trustees also employs employees to handle other day-to-day administrative management services.

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

UNION TRUSTEES

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

Tomas Fret
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, NY 11580

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

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

Vincent Buttaro, Alternate
Division 1181 A.T.U.
20 North Central Avenue
Valley Stream, NY 11580

EMPLOYER TRUSTEES

Neil Strahl, Secretary
Pioneer Transportation
2890 Arthur Kill Road
Staten Island, NY 10309

Stanley Brettschneider
Mintz & Gold LLP
600 Third Ave., 25th Fl.
New York, NY 10016

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at Fund Office all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor

and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary Plan description upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Eligible Retiree with a copy of the summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The Plan does not give you any right to continue in Employment. However, no one, including your Employer, your Union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

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

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