A Guide to Your Plan of Benefits

Summary Plan Description

Effective January 1, 2018

Local Union No. 373 U.A.
Health & Welfare Fund

Local Union No. 373 U.A. Health & Welfare Fund
PO Box 58, 76 Pleasant Hill Road, Mountainville, NY 10953 *Telephone: 845-534-9522 or 888-458-6777*

January 1, 2018

Dear Participant:

This booklet is a description of the Local 373 Health and Welfare Fund as it is in effect on January 1, 2018. There have been some changes in the Fund since the last booklet was written. We encourage you to familiarize yourself with this booklet and the Benefits that are available to you and your family.

This booklet has nine sections:

Section I. The Health and Welfare Program
Section II. The Vacation Program
Section III. Health Reimbursement Account
Section IV. Supplemental Unemployment Benefit Program
Section V. Claim Procedure
Section VI. Qualified Medical Child Support Order
Section VII. Your Rights Under ERISA
Section VIII. Protected Health Information
Section IX. Technical Details

The Fund is governed by a Board of Trustees of which half represent the union and half represent the participating employers. Our role, as Trustees of the Health and Welfare Fund, includes the responsibility for collecting contributions (which are required by an agreement between your employer and Local 373 or between your employer and the Trustees). The Board of Trustees has the ultimate responsibility for the management of plan assets. In addition, the Board of Trustees has the sole power to amend the Fund. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an accountant, an attorney, a consultant, and one or more investment managers.

The Fund Office, maintains the daily operation of the Fund. The staff are available to answer any questions or as a resource to obtain additional information about the Fund.

If, after having gone through the booklet thoroughly, you have any questions regarding the Fund or its operation, please do not hesitate to contact the Fund Office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Trustees, in writing.

Sincerely,

Board of Trustees,
Local Union No. 373 U.A. Health & Welfare Fund

Important Notice

The Trustees reserve the right to amend, modify or discontinue all or part on this Fund whenever, in their judgement, conditions so warrant. This booklet describes the Fund as it exists on January 1, 2018.

Caution

This booklet and the personnel at the Fund Office are authorized sources of Fund information for you. The Trustees of the Fund have not empowered anyone else to speak for them with regard to the Health and Welfare Fund. No employer, local business agent, supervisor or shop steward is in a position to discuss your rights under the Fund with authority.

Communications

If you have a question about any aspect of your participation in the Fund, you should, for your own permanent record, write to the Fund Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

No Guarantee Of Income-Tax Consequences

Neither the Board of Trustees nor the Fund Office makes any commitment that any amounts paid to or for the benefit of a Participant under this Fund will be excludable from the Participant's gross income for Federal or State income-tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant.

Important Government Notice Regarding the Fund's Grandfathered Status

The Health & Welfare Fund of Local Union 373 (the "Fund") believes the Fund 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 the law was enacted. Being a grandfathered health plan means that your Fund 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, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on 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 Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.bov/ebsa/healthreform. This website has a table summarizing which protections that do and do not apply to grandfathered health plans.

Fund Interpretations and Determinations

The Board of Trustees is responsible for interpreting the Fund and for making determinations under the Fund. In order to carry out their responsibilities, the Trustees, or their designees, have exclusive authority and full discretion to determine whether an individual is eligible for any benefits under the Fund; to determine the amount of benefits, if any, an individual is entitled to from the Fund; to determine or find facts that are relevant to any claim for benefits from the Fund; to interpret all of the Fund's provisions; to interpret all of the Summary Plan Description (the "Fund"); to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting the Fund; to interpret the provisions of the Trust Agreement governing the operation of the Fund; to interpret all of the provisions of any other document or instrument involving or impacting the Fund; and, to interpret all of the terms used in the Summary Plan Description, and in all of the other previously-mentioned agreements, documents, and instruments.

All such interpretations and determinations made by the Trustees, or their designees, shall be final and binding upon any individual claiming benefits under the Fund and upon all Participants, all Employers, the Union, and any party who has executed any agreements with the Trustees or the Union; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and, will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designees, abused their discretion in making such determination or rendering such interpretation.

Benefits under this Fund will be paid only if the Trustees decide in their discretion that you are entitled to them.

Important Notes

- You must notify the Fund Office if you have a change in address.
- You must notify the Fund Office of the birth or adoption of any new Dependents.
- You must notify the Fund Office if you and your spouse divorce or if your child ceases to qualify as a Dependent under the terms of the Fund.
- You should keep your life insurance beneficiary up to date.
- All claim forms must be submitted in a timely manner and completely filled in; incomplete or late forms will be denied or returned.
- You should familiarize yourself with this entire booklet.

Notification Requirement Upon Divorce

You have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced spouse and children of the divorced spouse (stepchildren of the participant) become ineligible for benefits upon the divorce. **If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to an ineligible Dependent, the Trustees may decide to recover those benefits by treating such benefits as an advance to you, and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered.** Also, if notice of divorce is not provided to the Fund Office within 60 days, your spouse and children of your divorced spouse will lose their right to elect COBRA Continuation Coverage.

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Important Aspects

- **Familiarize yourself with the whole booklet.**

- **All Benefits must be applied for.**

- **Make sure that the Fund Office is aware of all your dependents and your current address.**

- **Make sure your Death Benefit beneficiary designation is up to date.**

- **All claim forms must be completely filled in; incomplete claims will be returned.**

Plan Change Or Termination

The Trustees reserve the rights to change or discontinue (1) the types and amounts of Benefits under the Fund and (2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the Fund:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested at any time;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such right to modify or terminate is not contingent on financial necessity.

The nature and amount of Fund Benefits are always subject to the actual terms of the Fund as it exists at the time the claim occurs.

Modification Of Benefits & Eligibility Rules

This Summary Plan Description includes information concerning the Benefits provided by the Fund to participants, including employees, pensioners and dependents and the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of Benefits that an employee, pensioner or dependent might otherwise reasonably expect a plan to provide.

The Benefits and eligibility rules applicable to employees, pensioners and dependents have been established by the Trustees as part of an overall Benefit plan for participants. The right to amend or modify the eligibility rules and plan of Benefits for employees, pensioners and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of Benefits for employees, pensioners and dependents and the eligibility rules relating to qualification therefor are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

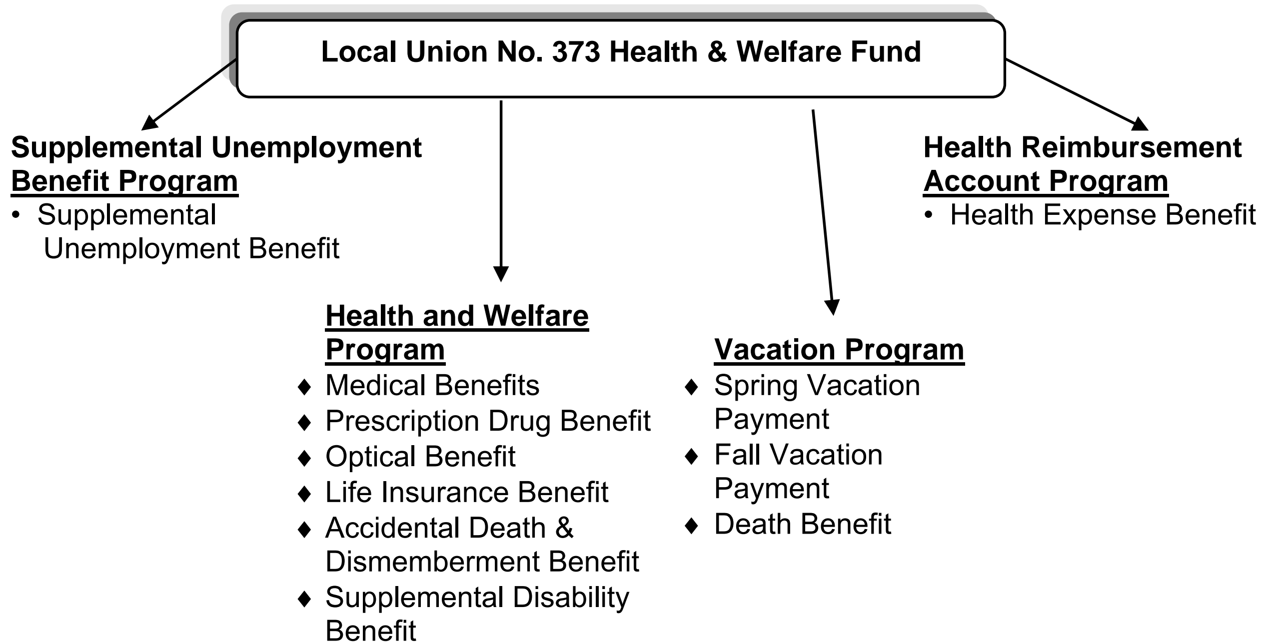
In accordance with the rules and regulations of the Fund and the Agreement and Declaration of Trust, no employee, pensioner or dependent has a vested right or contractual interest in the Benefits provided. In addition to the right to terminate Benefits of employees and/or pensioners and/or dependents at any time, in the event of termination of the Fund, the Trustees also reserve the right to terminate the plan of Benefits for employees and/or pensioners and/or dependents and there shall not be any vested right by any employee, pensioner or dependent or beneficiary nor contractual rights after the disposition of plan assets in connection with the termination of this Fund. The provisions for employees, pensioners and dependents' coverage shall be reviewed periodically by the Trustees.

Assets Of The Fund

The assets of the Fund consist of (1) the sums of money that have been or will be paid or which are due and owing to the Fund by the Employers as required by Collective Bargaining Agreements, (2) all investments made therewith, the proceeds thereof and the income therefrom, (3) all other contributions and payments to or due and owing to the Trustees from any source to the extent permitted by law and (4) supplies, property and other assets used by the Trustees in the administration of the Fund.

Introduction

The Local Union No. 373 U.A. Health and Welfare Fund is made up of four basic Programs; the Health and Welfare Program, the Supplemental Unemployment Benefit Program (S.U.B.), the Health Reimbursement Account (HRA) Program, and the Vacation Program. Each of the four Programs is divided into smaller categories called Benefits. The breakdown of these Benefits is outlined below.



The benefits under the Health and Welfare Program are self insured for active and pre Medicare retired participants with the exception of the Life Insurance and AD&D benefits which are fully insured. The Health and Welfare Program benefits for those retired participants eligible for Medicare are fully insured except for the optical and life insurance benefits which are self insured. The Fund Office and Empire Blue Cross Blue Shield jointly administer the Medical and Prescription Drug Benefits. They are intended to cover most traditional medical expenses such as hospital charges and physician's fees.

The three remaining programs are self insured and administered by the Fund Office.

The Vacation Program provides a means for you to save money to help cover your vacation expenses.

Each of the four Programs has separate and distinct eligibility requirements. It is possible, for example, to be covered by the HRA Program but not covered under the Health and Welfare Program.

This booklet is intended to help you gain a thorough understanding of all of the self-insured Benefits as well as each Program's eligibility rules.

Section I. The Health and Welfare Program

A. INTRODUCTION

The Health and Welfare Program consists of the following six Benefits:

- Medical Benefits,
- Prescription Drug Benefit,
- Optical Benefit,
- Life Insurance Benefit,
- Accidental Death & Dismemberment Benefit, and
- Supplemental Disability Benefit.

Each of these Benefits may have different conditions and maximum Benefit amounts. Also, not all classes of covered persons are entitled to all of the available Benefits.

An easy to follow table has been included in this section to give you a quick reference of the Benefits available under the Health and Welfare Program. Along with this table, is a description of each Benefit. A detailed description of Benefits insured through Ullico as well as those Benefits administered by Empire Blue Cross Blue Shield are contained in separate booklets provided by each respective company and may be obtained at the Fund Office.

B. INITIAL ELIGIBILITY REQUIREMENTS

You and your eligible dependents will be covered by the Health and Welfare Program on the first day of the month following your completion of a period of no less than six months and no more than twelve months during which you work at least 840 hours in covered employment.

Covered employment means work for which your employer is required to contribute to the Health and Welfare Fund because of his collective bargaining agreement or because he has a special agreement with the Health and Welfare Fund Trustees. Reciprocal time with certain other plans that the Health and Welfare Fund maintains reciprocal agreements with and for which the Fund receives contributions will also count as covered employment.

C. CONTINUING ELIGIBILITY REQUIREMENTS

Once your coverage begins, you are covered for the balance of that “quarter”. A coverage quarter is the three consecutive calendar month period that begins with January 1, April 1, July 1 or October 1. You will be covered for the next coverage quarter if you have been credited with at least 300 hours of covered employment during the immediately preceding eligibility quarter, or you have been credited with 600 hours of covered employment during the immediately preceding two (2) eligibility quarters.

This schedule is as follows:

Period of Coverage (Coverage Quarter)	Work 300 hours during (Eligibility Quarter)	Work 600 hours during:
01/01 – 03/31	08/01 – 10/31	05/01 – 10/31
04/01 – 06/30	11/01 – 01/31	08/01 – 01/31
07/01 – 09/30	02/01 – 04/30	11/01 – 04/30
10/01 – 12/31	05/01 – 07/31	02/01 – 07/31

At the end of each eligibility quarter, your work records will be reviewed to see if you have worked the required hours of covered employment necessary to continue coverage for the next coverage quarter. If you have not met the requirements for continued coverage, your last day of coverage will be the last day of the quarter for which you were last eligible for coverage. If you lose coverage because of insufficient hours and you are within 40 hours or less of the hours requirement you will be given the opportunity to self pay for the hours needed. You must pay the current Journeymen Welfare “A” rate.

If you believe you worked in covered employment that was not properly credited under the Fund, you have the right to submit a claim in accordance with the claims procedures described later in this summary. Please remember that, in the event of a discrepancy between the information and contributions received by the Fund from contributing employers and the contributions to which you believe you are entitled, it will be your responsibility to prove:

- that the work in question was actually performed by you for a Contributing Employer,
- the amount of work performed,
- that the work was covered employment for which contributions were required to be made to the Fund.

Therefore, it is important that you retain adequate records of your covered employment (for example, pay stubs, stamps and other documentary evidence) that would help you prove both the amount of work you performed for each Contributing Employer and that the work constituted covered employment. Please also remember that the longer you wait to file a claim to correct any issue, the more difficult it may be for you to provide, and for the Fund to verify, the necessary documentation.

The Fund generally determines both your initial and continuing eligibility based on the remittance reports submitted. While the Fund conducts random payroll reviews of Contributing Employers that sometimes provide information regarding the accuracy of remittance reports and other information submitted by employers, these reviews may not reveal every instance in which a Contributing Employer may have failed to provide complete and/or accurate information concerning your employment.

You have the right to inquire into your eligibility for participation and the level of your benefits under the Fund at any time.

The following special provisions allow you to continue your eligibility if you experience a layoff or you become disabled.

If you fail to work the required hours in covered employment in an eligibility quarter because of layoff (initiated by the Contributing Employer due to lack of work) and you are available for covered employment, you will be given the option of electing COBRA coverage or you may elect to self pay for coverage following the date you cease employment provided you are within 40 hours or less of the hours requirement. The Trustees will set the self pay rates annually.

If you become totally disabled while covered, you will continue to be eligible for the Health and Welfare Program for a period not to exceed three years from the date you last worked. To be considered totally disabled you must be unable to earn any money because of your illness, pregnancy or injury and you may be required to prove your disability periodically to the satisfaction of the Trustees.

D. REINSTATEMENT AFTER TERMINATION OF ELIGIBILITY

If your coverage is terminated, you must once again satisfy the initial eligibility requirements to have your coverage reinstated.

E. DEPENDENTS

Eligible dependents include your lawful spouse and your children who are under age 26. The term ”child” includes:

- your natural child,
- your adopted child,
- a child placed with you in anticipation of adoption,
- a step-child,
- an eligible foster child,
- a child for which you have been appointed legal guardian and who is living in your household, and
- your child who is designated as an alternate payee under a qualified medical child support order.

An eligible dependent will become eligible for dependent coverage on the first day that:

- you are eligible for employee coverage, and
- the family member satisfies the requirements for dependent coverage.

At any time the Fund may require proof that a spouse or child qualifies or continues to qualify as a dependent as defined by this Fund.

The following persons are excluded as dependents:

- other individuals living in your home but who are not eligible as defined,
- your former spouse (because of divorce),
- any person who is on active duty in any military service of any country, or
- any person who is covered under the Fund as an employee.

1. Duration Of Dependent Coverage. Your dependents' coverage ends when your coverage ends. The one exception to this rule is in the event of your death. If your coverage terminates because of your death, your dependent's coverage will continue for a period of 12 months from the date of your death. Also, if a dependent stops being an eligible dependent, his or her coverage will stop even if your coverage does not. For example, if you and your covered spouse divorce, his or her coverage will stop even though your coverage may continue.

2. Totally Disabled Children. Coverage for a dependent child will normally cease at the end of the calendar year in which he or she attains age 26. However, if a covered dependent child is totally disabled, coverage may be continued beyond age 26.

   To be considered totally disabled, your dependent child must be:

   - incapable of self-sustaining employment by reason of mental retardation or physical handicap,
   - primarily dependent upon you for support and maintenance,
   - unmarried, and
   - covered under the Fund when reaching age 26.

The Fund Office may require, at reasonable intervals during the two years following the dependent's 26th birthday, subsequent proof of the child's total disability and dependency. After the initial two-year period, the Fund Office may require subsequent proof not more than once each year. The Fund Office reserves the right to have a disabled dependent examined by a physician of the Fund Office's choice, at the Fund's expense, to determine the existence of a total disability.

3. Status. Under this Fund, you may only be covered as either an employee or a dependent at any one time. If conditions so warrant, you may change your status from employee to dependent or dependent to employee. If you do change status while you are covered continuously under this Fund (before, during or after the change in status), credit will be given for deductibles and all amounts applied toward maximums.

   If both spouses are employees, their eligible dependent children will be covered as dependents of either spouse but not as dependents of both.

F. PENSIONERS

1. Eligibility. If you retire under the Local 373 U.A. Pension Fund, you may elect to continue the Health and Welfare Program coverage as an eligible pensioner if the following eligibility requirements are satisfied:

   - you must have been continuously available for covered employment during the seven consecutive years prior to your pension date. Not being available for covered employment includes, but is not limited to, a participant who has been suspended from his Union, transferred to another Union, withdrawn from his Union or whose Union informs the Fund that the participant has not been available for covered employment. You will also be deemed unavailable for covered employment if you are working in other full time employment,

   - you must be covered by this Health and Welfare Program on the effective date of your pension, and

   - you must make timely premium payments to the Fund. If you fail to make timely premium payments, your coverage as an eligible pensioner will terminate and will not be reinstated.

2. Coverage For Spouses. If you qualify for Health and Welfare Program coverage as a pensioner, you may elect to continue coverage for yourself alone (single coverage) or yourself and your eligible spouse (married couple coverage). If you are married at retirement and elect single coverage, your spouse may not be added at a later date. However, if you are single at retirement and later become married, your new spouse may be added at that time. Furthermore, if your covered spouse dies and you remarry, your new spouse may be added at that time.

   Once you or your spouse become eligible for Medicare, your medical and prescription drug coverage will be provided through a fully insured Medicare Supplemental and Part D plan.

G. CONTINUED COVERAGE BY SELF-PAYMENT

In some circumstances, it may be possible for you and/or your dependents to continue coverage under the Health and Welfare Program even when your coverage would have otherwise terminated.

1. Continuing Coverage By Self-Payment Under COBRA. If your Health and Welfare Program coverage is terminated, you may be entitled to continue your medical and prescription drug coverage on a self-pay basis in accordance with The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

   You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. 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 doesn’t accept late enrollees.

   COBRA provides that under certain circumstances you and your dependents are entitled to elect to continue coverage on a self-pay basis under the Fund if coverage would otherwise stop. For individuals covered by the Fund as employees, COBRA continuation coverage may be elected upon loss of coverage under the Fund due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Fund.

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following qualifying events:

- your death;
- your spouse's loss of coverage under the Fund due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Fund due to a reduction in your hours of covered employment;
- divorce or legal separation; or
- your eligibility for Medicare (even if such eligibility occurs while you and/or your spouse is already receiving COBRA continuation coverage).

Your dependent children may elect COBRA continuation coverage upon the occurrence of any of the following qualifying events:

- your death;
- your dependent child's loss of coverage under the Fund due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Fund due to a reduction in your hours of covered employment;
- divorce or legal separation of the child's parents;
- your eligibility for Medicare (even if such eligibility occurs while you and/or your dependent child is already receiving COBRA continuation coverage); or
- the child ceases to qualify as an "eligible dependent" as described in Section I., E.

If, while you are receiving COBRA continuation coverage, you have a newborn child or adopt a child (or have a child placed with you for adoption), the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

Your employer has the obligation to notify the Fund Office of your death or your eligibility for Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Fund and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated when your regular group health care coverage terminates. You or one of your dependents who is eligible for COBRA continuation coverage has the obligation to notify the Fund Office of your divorce, legal separation or your child's loss of status as an eligible dependent. This notice must be given within 60 days after the occurrence of the event.

After the Fund Office receives notice of the occurrence of one of the qualifying events (listed above), it will notify each eligible individual of his or her right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Office will notify an eligible individual of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events or after it has determined that your regular group health care coverage has terminated.

Any person eligible for COBRA continuation coverage will have a period of at least 60 days from the date he or she would otherwise lose coverage under the Fund to advise the Fund Office that he or she elects COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate.

If election is made to continue coverage and the election is due to termination of your employment or a reduction in your hours of covered employment, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you or one of your dependents is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each covered individual can receive a total of 29 months on COBRA continuation coverage. For most other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

- The employer ceases to provide group health coverage,
- Your or your Dependents failure to pay the monthly premium on time,
- The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions,
- The individual becomes eligible for Medicare, or
- Circumstances are such that the individual's participation could be cancelled if the individual were an active employee.

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost that the Fund incurs annually per participant plus a two-percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Fund. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants.

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Office.

2. Continued Coverage By Self-Payment For Qualified Military Service. If you are on uniformed services leave for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

   If you are on uniformed services leave for more than 31 days, you will be permitted to continue medical and dental coverage for yourself and your dependents at your own expense to the extent required under USERRA. You may continue coverage for yourself and your Dependents for up to 24 months. If elected, USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage.

   The Fund will offer the employee USERRA continuation coverage only after the Fund Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders.

   Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately.

3. Continued Coverage Under The Family Medical Leave Act. Under federal law, you may be eligible for up to twelve weeks of unpaid leave from your employment for any of the following reasons:

   - you need to care for your newly-born or newly-adopted child,
   - you need to care for your spouse, child or parent who has a serious health problem, or
   - you have a serious health problem which prevents you from performing your job.

   If you qualify for such a leave, you (and your eligible dependents, if any) will continue to participate in the Fund just as if your work in covered employment had not stopped, unless your employer fails to make the required contributions for you. If you do not return to work at the end of your leave, you may be responsible for repaying the employer contributions made during the leave. You should contact your employer for further information about your eligibility for such a leave.

H. SCHEDULE OF BENEFITS

1. Medical Benefits. Medical Benefits are self insured and administered by Empire Blue Cross Blue Shield. Active employees, dependents and pensioners who are not yet Medicare eligible are eligible for Medical Benefits.

Medicare eligible pensioners and their Medicare eligible dependent are covered under a fully insured Medicare Supplement plan. The benefits are summarized in a booklet produced by the insurer. You can get more information from the Fund Office.

All of the Benefits are subject to other exclusions and limitations as described in the booklet provided by Empire Blue Cross Blue Shield.

Your Medical Benefits are provided through either a Participating Provider Organization (PPO) or a Point of Service (POS) plan. With a PPO and a POS plan, an agreement with certain hospitals, physicians and other health care providers is established. The hospitals, physicians and health care providers who have entered into this agreement are called participating providers (in-network provider). The participating providers have agreed to charge reduced fees, therefore, the Fund can afford to reimburse a higher percentage of their fees. When a participant uses a Participating Provider, that participant will receive a higher payment than when a non-participating provider is used. It is your choice as to which provider to use. Your out-of-pocket expenses differ depending on whether you use an in-network provider or an out-of-network provider.

The following table outlines the cost for which a participant is responsible. A more complete list can be found in the booklet provided by Empire Blue Cross Blue Shield available at the fund office.

	In Network	**Out of Network**
Annual Deductible	$0	$500/Individual $1,250/Family
Co-payment (for office visits and certain covered services)	$25 Primary co-payment per visit $40 Specialist co-payment per visit	N/A
Co-payment (for hospital inpatient admissions)*	$100 per admission	N/A
Co-payment (for ambulatory/outpatient surgery)	$75 co-payment	N/A
Co-payment (for emergency room)	$75 per visit (waived if admitted to hospital within 24 hours)	$75 per visit (waived if admitted to hospital within 24 hours)
Coinsurance	N/A	You pay 30% of maximum allowed amount. Fund pays 70% of maximum allowed amount
Annual Out-of-Pocket Coinsurance Maximum	N/A	$3,000/Individual $7,500/Family
Lifetime Maximum	Unlimited	$1 million

* Up to $250 maximum per contract year. Co-payment

Charges Related To A Mastectomy

Your benefit coverage includes charges incurred by you or your beneficiary in connection with a mastectomy covered by the Fund or insurance issuer, in a manner determined in consultation with the attending physician and you or your beneficiary, for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, provided you/your beneficiary elect breast reconstruction in connection with such mastectomy.

Mothers And Newborns

Group health plans and health insurance issuers generally may not, under the Newborns' and Mothers' Health Protection Act, 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).

2. <u>Prescription Drug Benefit</u> Participating pharmacies have contracted with the Fund to charge Covered Persons reduced fees for covered Prescription Drugs. Empire Pharmacy Management is the administrator of the pharmacy drug plan. A more complete outline of the Prescription Drug Benefit can be found in the Empire Blue Cross Blue Shield booklet available at the Fund Office. This coverage is provided to active employees, dependents and pensioners who are not yet Medicare eligible. Medicare eligible participants and their Medicare eligible dependents are covered under a fully insured Medicare Part D plan. These benefits are summarized in a separate booklet provided by the insurer. More information is available at the Fund Office.

a. Pharmacy Option

The copayment is applied to each covered pharmacy drug charge and is shown in the table listed below. The copayment amount is not a covered charge under the Medical Fund. Any one prescription is limited to a 30-day supply.

Copayment, per Prescription

For Generic drugs .... $10.00 or 10% whichever is greater
For Single Source Brand Name drugs .... $30.00 or 10% whichever is greater

b. Mail Order Prescription Drug Option

The copayment is applied to each covered mail order prescription charge and is shown in the table listed below. It is not a covered charge under the Medical Plan. Any one prescription is limited to a 90-day supply.

Copayment, per Prescription

For Generic drugs .... $20.00 or 10% of a 90 day supply whichever is greater
Brand Name drugs .... $60.00 or 10% of a 90 day supply whichever is greater

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Empire Pharmacy Management, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

3. Optical Benefit. Active employees, eligible dependents and pensioners are eligible for the Optical Benefit.

Under the Optical Benefit you and your eligible dependents will be entitled to reimbursement for the cost of an annual eye examination and one pair of prescription eyeglasses or contact lenses per year. The maximum amount of this Benefit is $100.00 every two calendar years (beginning with odd numbered years) per covered person. This Benefit does not apply to sunglasses whether prescribed or not.

4. Life Insurance Benefit. Active employees and pensioners are eligible for the Life Insurance Benefit; dependents are not eligible for this benefit.

The Life Insurance Benefit provides a Death Benefit to your designated beneficiary if you die while a participant in this Fund. The amount is $15,000 for active employees and $5,000 for pensioners. Ullico currently insures this Benefit for active employees; the Life Insurance Benefit for pensioners is self-insured. Please refer to the certificate of insurance provided by Ullico for a complete description of this Benefit.

5. Accidental Death & Dismemberment Benefit. Active employees and pensioners are eligible for the Accidental Death and Dismemberment Benefit; dependents are not eligible for this benefit.

If you suffer the loss of life, sight, hand or foot as a result of an accident and such loss occurs within 90 days of the accident, you will be paid in accordance with the following schedule:

Loss	Active Employee Benefit	Pensioner Benefit
Life	$15,000	$10,000
One member*	$7,500	$5,000
Two members*	$15,000	$10,000

* A member means a hand, a foot or loss of sight in one eye.

The Accidental Death and Dismemberment Benefit is currently insured by Ullico. Please refer to the certificate of insurance provided by Ullico for a complete description of this Benefit.

6. Supplemental Disability Benefit

Such benefit is in addition to your New York State Disability Benefits Law benefit, or Workers' Compensation benefit.

If you are unable to perform covered employment because of an injury, illness or pregnancy, you will be eligible to apply for a weekly Supplemental Disability Benefit. To be eligible for this Benefit, you must be under the care of a physician for such injury, illness or pregnancy. Furthermore, you must <u>not</u> be receiving a Disability Pension from the Local 373 U.A. Pension Fund or any other pension plan and you must not be entitled to a Social Security Disability Pension Benefit.

The Supplemental Disability Benefit is paid in accordance with the following schedule:

Weekly Benefit	
Employment related injury or illness	$105.00*
Non-employment related injury or illness First 26 weeks Next 13 weeks	 $105.00* $210.00*
Waiting Period for Disability	
Due to injury	None
Due to illness	7 days
Maximum Period of Benefits	
Employment related injury or illness	33 weeks
Non-employment related injury or illness	39 weeks

* Not to exceed 66 2/3% of average weekly earnings when combined with any state or group welfare program.

The Supplemental Disability benefit must be applied for on forms that are available at the Fund Office upon request. If you have any questions regarding the forms, don't hesitate to ask the Fund Office.

The Fund Office can acquaint you with the type of acceptable proof.

Section II. The Vacation Program

A. INTRODUCTION

The purpose of the Vacation Program is to make it possible for you to enjoy the healthful effects of a vacation. You are encouraged to take a vacation at a time that is beneficial to both you and your employer.

B. INTIAL & CONTINUING ELIGIBILITY REQUIREMENTS

If your employer is required to contribute to the Vacation Program for you, you become a participant as soon as money is received. You remain a participant as long as there is money in your Vacation Program account.

Your Vacation Program account consists of the amounts contributed to the Fund by your employers on behalf of your work, less any distributions made from your account.

C. VACATION PROGRAM PAYMENTS

1. Spring Vacation Payment. Around May 1 of each year, the Fund Office will distribute to you, in a single check, the portion of your account attributable to your work in the previous calendar year less any distributions for that previous calendar year.

2. Fall Vacation Payment. Around December 1 of each year, the Fund Office will distribute to you, a single check in the following amount:

   Journeymen will receive the equivalent of one weeks' Zone One journeyman's gross wages. Apprentices will receive the equivalent of one weeks' Zone One fifth year apprentice's gross wages. (Or, in all cases, the balance of your account, whichever is less).

3. Death Benefit. If you pass away, any balance in your account will be distributed, in a lump sum, to your designated beneficiary.

Section III. The Health Reimbursement Account Program

A. INTRODUCTION

The Health Reimbursement Account Program is designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. The Health Expense Benefit is available to you under the HRA Plan, if you are eligible.

B. INITIAL & CONTINUING ELIGIBILITY REQUIREMENTS

If your employer is required to make contributions to the HRA Program, you become a participant as soon as the contributions are made. You remain a participant as long as there is a balance in your account.

Your account will grow with all the contributions that are made to it in the future. Your account will be decreased by any Benefit distribution made from it. No more will be paid out to a Fund participant (or beneficiary) under this Program than has come into his or her HRA Program account by way of contributions made on behalf of his or her work.

C. SCHEDULE OF BENEFITS

Health Expense Benefit. The Health Expense Benefit is available to eligible active employees and eligible pensioners.

If you incur health care expenses while you are a participant in the Fund, for yourself, your spouse, or your dependent child, and these expenses are not covered under the Health and Welfare Program or any other insurance, you may apply for a distribution of a portion of your account to pay for the uncovered bills.

These expenses may include, but are not limited to the following:

- dental expenses,
- eye care expenses,
- hearing aids,
- Health and Welfare Program deductibles, co-insurance and co-payments, and
- Health and Welfare Program required premium co-payments.

Claims under this Benefit may be submitted only if they total at least $25. You may add several bills together in order to reach the $25. Also, claims for reimbursement under this Benefit must be made within twenty-four (24) months from the date the expense was paid.

Section IV. The Supplemental Unemployment Benefit Program (S.U.B.)

A. INTRODUCTION

The S.U.B. Program is effective 5/1/05. The general purpose of the S.U.B. Program is to provide a supplemental weekly income to you when you are not working due to unemployment. Such benefit is in addition to your state unemployment benefit or "No Fault" benefit for a supplemental unemployment benefit.

B. INITIAL AND CONTINUING ELIGIBILITY REQUIREMENTS FOR A SUPPLEMENTAL UNEMPLOYMENT BENEFIT

For each week for which you want a payment you must satisfy the "service", "available", and "unemployed" requirements.

1. You must have worked in covered employment at least 800 S.U.B. Hours in the Plan Year immediately before the Plan Year for which you want payment.

   A S.U.B. Hour is an hour of your time for which contributions are required to be made to the Local 373 Supplemental Unemployment Benefit Fund. This term is important in fulfilling the service requirement for benefits.

2. You must show that you are available for covered employment. You must meet each of the following conditions:

   - You must be registered with Local Union 373 as out of work and available for work;

   - You must not refuse covered employment if it's offered to you (of course, if you refuse Covered employment for a day on which you are totally disabled, that will not count against you);

   - You must not be receiving a pension benefit from Local Union 373 U.A. Pension Fund or any other pension plan.

3. You must be unemployed for a week (seven consecutive days Monday through Sunday).

If you receive a payment under New York State Unemployment Insurance system for the week, or such week is the "waiting week" under the State system, then you have satisfied the "unemployed" requirement for that week.

C. S.U.B. PROGRAM PAYMENTS FOR A SUPPLEMENTAL UNEMPLOYMENT BENEFIT

The weekly benefit payment is $100.00. This is a gross payment and the only tax that will be withheld will be Federal. You will receive a W-2 at the end of the year for tax purposes.

No more than one $100.00 payment may be made to any one person for one week. You cannot draw both a supplement unemployment payment and supplemental disability for the same week. No more than 10 weekly S.U.B. benefit payments may be made to any one person for any one Plan Year for reason of unemployment under this Fund.

D. APPLICATION PROCEDURE

Each weekly S.U.B. benefit must be applied for on forms that are available at the Fund Office upon request. If you have any questions regarding the forms, don't hesitate to ask the Fund Office.

No benefit will be paid for an unemployment week more than 60 days ago.

Proof of reception of a State Unemployment Insurance payment must be submitted for the supplemental unemployment payment. A certification form should be secured from the Fund Office.

Section V. Claims Procedure

A. GENERAL PROVISIONS

Other Benefits

Claims for the Supplemental Unemployment Benefit Program, the Vacation Program and the Health Reimbursement Program, are administered by the Fund Office. In addition the optical, life insurance, AD&D, and Supplemental Disability benefits are processed by the Fund Office. Application for these benefits must be made in writing on forms that can be obtained from the Fund Office. You may secure such forms by writing, telephoning, or visiting the Fund Office. The Fund Office address and telephone number are:

76 Pleasant Hill Road
Mountainville, NY 10953
(845) 534-9522

The Trustees will have the right and opportunity to examine any claimant (while living) when and so often as may be reasonably required and, also, the right and opportunity to make an autopsy where it is not forbidden by law.

Medical Claims

All medical claims are processed by Empire, a Third Party Payer. If you have questions regarding the status of a claim, how the claim was processed, or your explanation of benefits, call Empire toll free at 1-800-342-9816 or 1-800-453-0113. You may also write to Empire at:

Empire Blue Cross Blue Shield (Empire)
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

All medical claims must be submitted directly to Empire at the above address.

Your claim will go through a re-pricing process at Empire, and will be reviewed for compliance with the “usual and customary” rate. **PLEASE NOTE THAT THERE WILL BE A DELAY IN PAYMENT ON MEDICAL CLAIMS MADE DIRECTLY TO THE FUND OFFICE.**

Prescription Drug Benefit

The prescription drug benefit is administered by Empire Pharmacy Management. You may obtain prescriptions at participating pharmacies by presenting your identification card and paying co-payments, without submitting a paper claim. If you need assistance, or a claim form, please call the Member Services phone number, (800) 342-9816, found on the back of your identification card.

B. FILING DEADLINE

You are encouraged to submit your claims as soon as possible to avoid failing to meet the deadline for submitting claims (which is the calendar year following the calendar year in which the expense was incurred). Claims submitted after the filing deadline will not be paid.

C. CLAIM DENIAL AND APPEAL

Initial Decisions

Time Frames

Self-Insured Medical and Prescription Drug (Administered by Empire); and all other benefits (Administered by the Fund Office).

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Fund condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Fund approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

Pre-Service Claims

For Pre-Service Claims, you will be notified of the benefit determination by Empire, the third-party administrator (whether adverse or not) within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Fund's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and the date by which the third-party administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the third-party administrator will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the third-party administrator regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow the filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. You will be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. Notification of the decision on that claim will then be provided within 48 hours after the third-party administrator's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination by Empire (the third-party administrator for the Self-Insured Medical and prescription drug benefits), or the Fund (for all other benefits) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended up to 15 days for matters beyond the Fund's control if, before the end of the initial 30-day period, the third-party administrator or the Fund (as applicable) notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Concurrent Care Claims

If the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatment.

Supplemental Unemployment or Supplemental Disability Benefits

If your claim for Supplemental Unemployment or Disability Benefits is denied in whole or in part for any reason, then within 45 days after the Fund receives your claim, the Fund will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Fund. For any extensions, the Fund will provide advance written notice indicating the circumstances requiring the extension and the date by which the Fund Office expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must supply the additional information.

Life Insurance and Accidental Death & Dismemberment Benefits

If your claim for Life Insurance or Accidental Death & Dismemberment Benefits is denied in whole or in part for any reason, then within 90 days after the Fund receives your claim, the Fund will send you written notice of its decision, unless special circumstances require an extension, in which case the Fund will send you written notice of the decision no later than 180 days after the Fund receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Fund expects to render the benefit determination. However, any decision regarding life insurance coverage that is based on a finding of total and permanent disability is subject to the same rules that apply to Supplemental Disability claims.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. In a case of an adverse determination involving a claim for urgent care, a description of the expedited review process applicable to such claims;

6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, guideline, or protocol, or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and

7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Fund's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in this Fund; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Self-Insured Medical, Prescription Drug or Health Expense Benefit claim you must appeal to the Trustees within 180 days after you receive the initial adverse benefit determination.

To appeal an adverse benefit determination of a Supplemental Disability Benefit, you must follow the procedures set forth in this Summary Plan Description and must be given at least 180 days to file an appeal. To appeal an adverse benefit determination of a Life Insurance or Accidental Death and Dismemberment benefit, you must follow the procedures set forth in this Summary Plan Description and must be given at least 60 days to file an appeal. Notwithstanding anything in this or the preceding paragraph to the contrary, for Concurrent Care Claims involving a reduction or termination of a preapproved, ongoing course of treatment, you will be afforded only a reasonable period of time to appeal.

Special Rule Regarding Urgent Care Claims If urgent care claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the plan's benefit determination on review, shall be transmitted between you and the Fund by telephone, facsimile, or other similarly expeditious method.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED __________, 20__." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, you must sign such statement and your appeal must include a copy of the written authorization. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, all appeals other than those involving the Life Insurance and Accidental Death and Dismemberment Benefits must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the initial adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Fund, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal

Time Frames

Pre-Service Claims for Self-Insured Medical Benefits: The Fund will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the request for review (except if the Fund provides two levels of appeal, the decision has to be made within 15 days at each level).

Urgent Care Claims: The Fund will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Self-Insured Medical Benefits: The Fund will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after receipt of the request for review (except if the Fund provides two levels of appeal, the decision has to be made within 30 days at each level).

Life Insurance, Accidental Death and Dismemberment, Supplemental Disability and all other claims: The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Fund will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Fund's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;

2. Reference to specific plan provisions on which the determination is based;

3. A statement that the claimant is 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;

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

<u>The Trustees' Decision is Final and Binding</u>

No participant, beneficiary or other person or entity shall have any right or claim to benefits under the Fund, or any right or claim to payment from the Fund, except as specified herein. Any dispute as to eligibility, type, amount, or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board of Trustees under and pursuant to the provisions of the Fund. The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Fund. Any legal action against this Fund must be started within 90 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. You may not start a lawsuit to obtain benefits or redress any dispute discussed above until after you have requested a review and a final decision has been reached on review. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled. Any legal action related to the Fund may only be brought in the United States District Court for the Southern District of New York.

D. INCOMPETENCE

In the event, it is determined that a claimant is unable to care for his or her affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representatives, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

E. COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Fund. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of Benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods and procedures as they consider advisable.

F. CLAIM REPRESENTATIONS

The Trustees will have the right to recover any Benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any Benefit payments made in error. If you are overpaid or otherwise paid in error, you are required to return any overpayment or erroneous payment.

G. BENEFITS COVER SPECIFIC CLAIMS ONLY

Notwithstanding any other provision of this Booklet, benefits available from the Fund provide only for the payment of certain specific expenses. Benefits do not cover illnesses, conditions, diseases, injuries, etc. Thus, while this Fund will make payments for certain expenses you incur with respect to certain illnesses, conditions, diseases, injuries, etc., the Fund does not provide for payment of all of the expenses you incur with respect to a particular illness, condition, disease, injury, etc.

H. FUND INTERPRETATIONS AND DETERMINATIONS

The Trustees are responsible for administering this Fund. In order to carry out their responsibility, the Trustees have exclusive authority and discretion:

- to determine whether anyone is eligible for any benefits under this Fund;
- to determine the amount of benefits, if any, anyone is entitled to from this Fund;
- to determine or find facts that are relevant to any claim for benefits from this Fund;
- to interpret all of this Booklet's provisions;
- to interpret the provisions of any Collective Bargaining Agreement or written agreement involving or impacting this Fund;
- to interpret the provisions of the Trust Agreement governing the operation of this Fund;
- to interpret all of the provisions of any other document or instrument involving or impacting this Fund; and
- to interpret all of the terms used in this Booklet, and all of the other previously mentioned agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under this Fund and upon all Employees, Dependents, Employers, the Union, and any party who has executed any agreement with the Trustees, or the Union; shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and, will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

I. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all Participants (including Pensioners), and their covered Spouses and Dependents, with respect to all of the Benefits provided under this Fund. For the purposes of this provision, the terms "you" and "your" refer to all Participants, (including Pensioners), covered Spouses and covered Dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this Fund pays Benefits in such situations.

These rules have two purposes. First, the rules ensure that your Benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Fund must be reimbursed for the relevant Benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

1. RIGHTS OF SUBROGATION AND REIMBURSEMENT. If you incur covered expenses for which a third party may be liable, you are required to advise the Fund of that fact. By law, the Fund automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation right, the Fund has the right to be reimbursed for payments made on your behalf under these circumstances. The Fund must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment. The Fund's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine.

No Fund Benefits will be advanced unless you (or your authorized representative if you are a minor or you cannot sign), and your attorney (if any) sign this Fund's lien form within six (6) months from the date of the event causing your illness or injury. If litigation is commenced, you must give five (5) days' prior notice to the Fund of any pre-trial conference, and the Fund has the rights to attend any such conference. You must also notify the Fund before you retain another attorney or an additional attorney since that attorney must also execute the form. IN NO EVENT, SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE FUND'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

If any disability benefits are paid by the Fund, Section 227 of the New York Workers' Compensation Law requires that you give notice to the Fund within ninety (90) days of the commencement of any action against the liable third party. You are also required to obtain the written consent of the Fund prior to the compromise of any cause of action.

2. ASSIGNMENT OF CLAIM. You may not assign any rights or causes of action that you may have against any third-party without the express written consent of the Fund. The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the Benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

3. FAILURE TO DISCLOSE AND/OR COOPERATE. If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party as well as for the Fund's attorney's fees and costs incurred in recovering that amount. **This Fund may offset the amount you owe from any future claims submitted by you as well as by your Dependents and Beneficiaries and/or will discontinue benefits to you, your Dependents and Beneficiaries, or, if necessary, take legal action against you. The Fund may also recover the amount you owe from your Health Reimbursement Account. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.**

4. RIGHT TO CEASE PAYMENT ON YOUR BEHALF. If you or a third party on your behalf is paid benefits from the Fund in an improper amount or otherwise receive Fund assets not in compliance with the Fund (hereinafter "Overpayments" or "Mistaken Payments"), the Fund has the right to start paying the correct benefit amount, cease payments, enforce its subrogation rights, and/or seek recovery of any Overpayments or Mistaken Payments. Payment of benefits to you or on your behalf does not constitute a waiver of the Fund's rights under this section.

J. COORDINATION OF BENEFITS WITH OTHER COVERAGE

In the event you have coverage under another plan that provides health care benefits, there will be a coordination of benefits regarding the health care reimbursement of this Fund. This coordination will apply in the event a covered expense is incurred under this Fund, which also is covered under other programs. A determination will be made as to which plan is the "first" plan. The method of determining which plan is "first" is:

- If the other plan does not have a coordination of benefits provision with regard to the particular expense, it is the first plan regardless of the following rules for such determination.

- The plan that covers the patient as a current employee is the first plan.

- If the patient is a Dependent child of parents not separated or divorced, then the plan covering the parent whose birth date falls earlier in the calendar year pays first. If the other plan does not use the birthday rule, then the plan that covers the father as a current employee is the first plan, unless the first plan is already determined by the first or second bulleted item above.

When the parents of such Dependent are separated or divorced, then the following rules apply:

- The plan that covers the parent with custody of the Dependent, who has not remarried, is the first plan.
- If the parent of the Dependent has remarried, the plan that covers the Dependent as a Dependent of the parent (or stepparent) with custody is the first plan.
- If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the Dependent, the plan which covers the Dependent as a Dependent of the parent with such financial responsibility is the first plan.
- If the other plan has a provision that it is always secondary, then this plan will be secondary in coordination with such plan.
- If none of the above criteria establishes which plan is the first plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the first plan.
- In the event that a Dependent child's coverage under the Dependent child's spouse's plan began on the same day as the Dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule described above.

If this Fund is the second plan, it will pay its benefits as if there were no other such plan, except that this Fund will pay no greater part of a charge covered by this Fund and another plan(s) than that which when added to the part(s) payable by the other plan(s) equals 100% of such charge.

If you are an active employee or a Dependent of an active employee under age 65, this Fund will be considered the primary plan for you even if you are eligible for Medicare by reason of disability caused by an illness other than End Stage Renal Disease.

This Fund will only coordinate with an HMO when the HMO participant obtains treatment within the HMO network. In addition, any penalty that is imposed by a plan for not obtaining a referral, not obtaining a second surgical opinion, pre-admission review or other cost containment measures will not be considered a covered expense under this Fund.

K. COORDINATION OF BENEFITS WITH MEDICARE

When you become eligible for Medicare, the Fund will treat you as if you are insured under Parts A. and B. of Medicare. Therefore, we suggest that at least three months before you reach age 65, or three months before you receive your 24th Social Security disability pension payment, you contact your local Social Security Office. This is necessary in order to insure that as soon as you are eligible, you are adequately covered by Medicare, which includes both Part A for hospital coverage and Part B for medical expenses.

Medicare will be considered as the secondary payer for all active employees (and all Dependents of active employees), and this Fund will be primary. However, this Fund will not be the primary carrier for eligible workers who:

- work for an employer that does not have 20 or more employees (including Fund Participants and employees who are not eligible for coverage under this Fund) for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding year; or

- are an active Participant age 65 and over who has end stage renal disease and is, or would upon proper application be, entitled to benefits under the Medicare End Stage Renal Disease Program.

This Fund will also be primary and Medicare will be secondary for 30 months for eligible individuals under age 65 who have Medicare solely because of permanent kidney failure. Thereafter, Medicare will be primary.

If Medicare is your primary plan, health care benefits provided by the Fund will be reduced by 1) any amount payable under Part A or Part B of Medicare, and 2) any amount which would have been payable had the covered person enrolled in Part A and Part B.

L. RECOVERY OF OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that you or a third party are paid Benefits from the Fund in an improper amount or otherwise receive Fund assets not in compliance with the Fund (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct Benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party. You, the third party, or the individual or entity receiving the overpayment or mistaken payment may be required to pay back the overpayment or mistaken payment to the Fund with interest at 14% per year. This recovery may be made by reducing other Benefit payments made to or on behalf of you or your dependents by commencing a legal action or by any other method the Trustees determine to be appropriate. You, the third party, or other individual or entity shall reimburse the Fund for attorney's fees, paralegal fees, court costs, disbursements and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of Benefits. The determination as to these matters is solely made by the Trustees.

M. ANTI-ASSIGNMENT

The benefits contained in this Fund, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. Any payment by the Fund directly to a Provider pursuant to a written election or purported assignments submitted by a Participant or Dependent is provided at the discretion of the Board of Trustees as a convenience to the Participant or Dependent and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action by the law provider.

VI. Qualified Medical Child Support Order

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate recipients." Both you and your beneficiaries can obtain, without charge, a copy of the Fund's QMCSO procedures from the Fund Administrator.

Upon receipt of a medical child support order, the Fund Administrator will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a Participant under the Health Fund and will receive copies of summary plan descriptions, summary annual reports, and summaries of any amendments made to the Fund according to current ERISA requirements.

VII. Your Rights Under ERISA

As a participant in the U.A. Local 373 Health & Benefit Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- **Receive Information About Your Fund and Benefits.** Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Fund, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

  Receive a summary of the Fund's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue Group Health Fund Coverage.** Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation coverage rights.

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

- **Prudent Actions by Fund Fiduciaries.** In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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 Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions.** If you have any questions about your plan, you should contact the Fund 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 Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor at:

JFK Federal Building
Room 3575
Boston, MA 02203
(607)565-9600

or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at:

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.

VIII. Protected Health Information

This Section describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. Protected Health Information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your protected health information.

A. PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how we are most likely to use and/or disclose your protected health information.

1. Payment and Health Care Options

We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule).

2. Payment

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

3. Health Care Options

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

4. Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management.

5. Other Covered Entities

We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

6. Fund Sponsor

We may disclose your protected health information to the plan sponsor or the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

B. POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

C. OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1. Required by Law

We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

2. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government that is collaborating with the public health authority.

3. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

4. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose your information to a governmental entity authorized to receive such information if we believe that you have been victim of abuse, neglect, or domestic violence.

5. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule not accompanied by a court order including (a) the requesting party must give the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice; (b) the notice

provided sufficient information about the proceeding to permit you to raise an objection; and (c) no objections were raised or objections raised were resolved in favor of disclosure by the court. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

6. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

7. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donations and transplantation.

8. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

9. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

10. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

11. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

12. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

13. Others Involved in your Health Care

Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

D. REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following is a description of disclosures that we are required by law to make:

1. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA Privacy Rule.

2. Disclosures to You

We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We are also required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat that person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

E. OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

F. YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

1. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by calling us at the number/writing to: *Karen Brennan, Office Manager, Local Union No. 373 U.A. Health Fund, 76 Pleasant Hill Road, Mountainville, NY 10953, (845) 534-9522 or (888) 458-6777.*

It is important that you direct your request for restriction to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the number/address indicated might delay processing the request. Requests that the Fund restrict use or disclosure of protected health information must be submitted in writing and the Fund Office will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

2. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by calling/writing: *Karen Brennan, Office Manager, Local Union No. 373 U.A. Health Fund, 76 Pleasant Hill Road, Mountainville, NY 10953, (845) 534-9522 or (888) 458-6777.* It is important that you direct your request for confidential communications to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. This request must be made in writing and the Fund Office will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB"). Therefore, it is extremely important that you contact us *as soon as* you determine that you need to restrict disclosures of your protected health information.

If you terminate your request for confidential communications, the restriction will be removed for all your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

3. Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a "designated record set". Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request in writing to the address listed in this Notice. It is important that you address your written request for an inspection and copying so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the address provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

4. Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing to *Karen Brennan, Office Manager, Local Union No. 373 U.A. Health Fund, 76 Pleasant Hill Road, Mountainville, NY 10953, (845) 534-9522 or (888) 458-6777.* Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

5. Right of an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations, and therefore, will not be subject to your right to an accounting. There also are other exceptions to this right. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to *Karen Brennan, Office Manager, Local Union No. 373 U.A. Health Fund, 76 Pleasant Hill Road, Mountainville, NY 10953, (845) 534-9522 or (888) 458-6777.* It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

6. Right to a Paper Copy of the Notice of Privacy Practices

You have a right to a paper copy of such Notice, even if you have agreed to accept such Notice electronically.

G. COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by writing to us. A copy of the complaint form is available from this contact office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Section IX Technical Details

(As required by the Employee Retirement Income Security Act of 1974)

1. **FUND NAME:** Local Union No. 373 U.A. Health and Welfare Fund.

2. **EDITION DATE:** This summary plan description is produced as of January 1, 2018.

3. **FUND SPONSOR:** Board of Trustees of Local Union No. 373 U.A. Health and Welfare Fund.

4. **FUND SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 13-3593163.

5. **PLAN NUMBER:** 501 (assigned by federal government)

6. **TYPE OF FUND:** Health and Welfare Fund

7. **FUND YEAR ENDS:** December 31.

8. **FUND ADMINISTRATOR:** Board of Trustees of Local Union No. 373 U.A. Health and Welfare Fund, 76 Pleasant Hill Road, PO Box 58, Mountainville, NY 10953

9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Riccardo Iaccarino, Esq., Barnes, Iaccarino & Shepherd, LLP, Three Surrey Lane, Hempstead, NY 11550.

In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Fund Trustee.

10. **TYPE OF FUND ADMINISTRATION:** Direct employees of the Board of Trustees.

11. **TYPE OF FUNDING:** Some Benefits are insured; some are self-insured.

12. **SOURCES OF CONTRIBUTIONS TO FUND:** Employers required to contribute to the Local Union No. 373 U.A. Health and Welfare Fund, certain Benefit funds with whom this Fund has reciprocal agreements, and, in certain circumstances, participants.

13. **COLLECTIVE BARGAINING AGREEMENTS:** This Fund is maintained in accordance with a collective bargaining agreement. A copy of this agreement may be obtained by you upon written request to the Fund Office and is available for examination by you at the Fund Office.

14. **PARTICIPATING EMPLOYERS:** You may receive from the Fund Office, upon written request, information as to whether a particular employer participates in the sponsorship of the Fund. If so, you may also request the employer's address.

15. FUND BENEFITS PROVIDED BY: The Local Union No. 373 U.A. Health and Welfare Fund and the Ullico.

16. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE FUND: See Section I. of this booklet.

17. HOW TO FILE A CLAIM: See Section V. of this booklet.

18. REVIEW OF CLAIM DENIAL: If you submit a Benefit application to the Fund or an Insurance Company, and it is denied, in whole or part, you will be so notified.

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees (or the Insurance Company, if appropriate) within 60 days of the denial, at the Fund Office asking that a review of the denial be made. You or your representative, may review the pertinent records and documents and you may appear at the review hearing.

After the review, you will be notified of the results of the review. More specific information regarding this procedure may be obtained from the Fund Office.

After a participant that has filed an appeal has received a written decision from the Board of Trustees, the participant will have 90 days to commence any further legal action, after which, no legal action may be commenced against the Fund and/or the Board of Trustees.

19. NO INSURANCE UNDER THE PBGC: Since this Fund is not a Defined-Benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

20. TRUSTEES: The Fund Sponsor and Fund Administrator is the Board of Trustees. The following are the individual Trustees that make up the Board as of January 1, 2018.

Employer

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