LOCAL 282

Welfare Trust Fund

Summary Plan Description

Effective as of July 1, 2019

LOCAL 282
WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

2500 Marcus Avenue
Lake Success, NY 11042
(516) 488-2822
(718) 343-3322

Effective as of July 1, 2019

LOCAL 282 WELFARE TRUST FUND

September 2019

Dear Participant:

We are pleased to provide you with this revised and updated summary plan description ("SPD"). This document describes all benefits available to you and your Dependents under the Local 282 Welfare Trust Fund (the "Fund") as of July 1, 2019.

The plan of benefits to which you are entitled varies depending upon your Employer and the industry in which you work. The eligibility rules are set forth on pages 22 through 26. For a summary of the benefits available under a specific benefit plan, refer to the Schedule of Benefits for that benefit plan. The Schedules of Benefits can be found on pages 16-18 of this SPD. Each Schedule shows the benefits that are available under each benefit plan and the page numbers on which the benefits are described in greater detail. Information on benefits available to pensioners can be found on page 19.

You and your Dependents should become familiar with the information in this SPD. Your knowledge of the eligibility rules and the benefits available will be of significant help to you and your family. If you have any questions or require any assistance with eligibility, benefits or claims, the Fund Office will be pleased to help you.

The benefits and eligibility requirements described in this SPD are not guaranteed and may be changed, reduced or eliminated at any time in the sole and exclusive discretion of the Board of Trustees. In addition, the Board of Trustees has the sole and absolute right, authority, and discretion to interpret, amend, or modify the terms of this SPD. If any benefit changes occur, the Fund Office will notify all participants in a timely fashion.

The Trustees of the Welfare Trust Fund will continue to make every effort to provide the best possible program of health benefits for you and your family. If you have trouble understanding any part of this material, get in touch with the Fund Office by utilizing the information under "Contact Information" on page 102 of this SPD.

This SPD reflects the benefits generally applicable to your coverage, although the benefits contained in the SPD may be revised from time to time. Accordingly, it is absolutely necessary that you verify coverage with the Fund Office before incurring medical charges so that you can be sure that there is coverage under the Fund for you or your Dependents. No one other than Fund personnel can verify your coverage.

Sincerely,
BOARD OF TRUSTEES
LOCAL 282 WELFARE TRUST FUND

LOCAL 282 WELFARE TRUST FUND

2500 Marcus Avenue
Lake Success, NY 11042
(516) 488-2822
(718) 343-3322

UNION TRUSTEES

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Consultant and Actuary
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Certified Public Accountant
Gould, Kobrick & Schlapp

This document is a summary plan description ("SPD") of a group health plan. This document contains a description of the rights and benefits that pertain to you under the Fund and your responsibilities relating to that Fund. This booklet describes the benefits available to you under the Fund and also constitutes the Fund's formal plan document.

No local union, local union officer, business agent, local union employee, employer or employer representative, association or association representative, individual Trustee, consultant, attorney or any other person may speak for or on behalf of this Fund, or commit or legally bind the Board of Trustees in any matter whatsoever relating to the Fund, unless such person shall have been given express authority from the Board of Trustees to act in such matter. Statements by the Fund Office, whether oral or written, cannot modify the benefits described in this booklet. All inquiries, requests for ruling, interpretations, or decisions, or questions of any kind concerning the contents of this SPD must be directed to the full Board of Trustees in care of the Fund Office. The statutory administrator of this Fund is the Board of Trustees.

This Fund is maintained pursuant to one or more Collective Bargaining Agreements. A copy of any such Agreement may be obtained by Participants and Beneficiaries upon written request to the Fund Office, and is available for examination by Participants and Beneficiaries.

This SPD is not a contract, and the benefits described herein are not contractual benefits. Accordingly, the benefits described herein may be changed, reduced, modified or discontinued and/or terminated in whole or in part at any time by the Board of Trustees. The Trustees do not promise to continue the benefits described herein in full or in part in the future, even if you have already established eligibility for any of the benefits.

The Trustees are authorized and empowered to interpret the meaning of any term in this SPD, including, but not limited to, any doubtful or ambiguous or conflicting provision(s) of this SPD. Any construction hereof adopted by the Trustees in good faith shall be binding upon the Union, the Contributing Employers, and all Participants and Dependents. The Trustees are authorized and empowered to determine a Participant's or a Dependent's entitlement to or application for benefits under the Fund, and any such decision of the Trustees shall be final and binding. For further information, please refer to the Claims & Appeals section of this SPD.

Except as the content may specifically require otherwise, use of the masculine or feminine pronoun shall be understood to include all individuals.

IMPORTANT! AS A PARTICIPANT YOU MUST NOTIFY THE FUND OFFICE IMMEDIATELY IF. . .

- **You get married;**
- **Your Spouse has health coverage through an Employer;**
- **A child is born or a child is placed with you for adoption;**
- **A death occurs in your family;**
- **You change your address;**
- **You are divorced or legally separated;**
- **Your child loses his/her status as a Dependent under the Fund;**
- **You want to change your Beneficiary for life insurance or accidental death and dismemberment insurance;**
- **Your coverage under this Fund terminates, and you want to continue certain available benefits at your own expense; or**
- **You become disabled, whether you are active or retired.**

PARTICIPANTS RECEIVING WORKERS' COMPENSATION BENEFITS MUST NOTIFY THE FUND OFFICE IMMEDIATELY SO THAT COVERAGE MAY BE CONTINUED FOR THE PERIOD PERMITTED.

SATISFACTORY PROOF OF MARRIAGE, DATE OF BIRTH, ADOPTION OF A CHILD, DIVORCE AND/OR LEGAL SEPARATION MUST BE SUBMITTED TO THE FUND OFFICE. NEW PARTICIPANTS ARE REQUIRED TO SUBMIT SATISFACTORY PROOF OF DEPENDENTS TO THE FUND OFFICE UPON INITIAL ENROLLMENT.

IF YOU GET DIVORCED AND FAIL TO NOTIFY THE FUND OFFICE OF YOUR DIVORCE WITHIN 60 DAYS, YOU AND/OR YOUR FORMER SPOUSE MAY BE LIABLE FOR ANY AND ALL CLAIMS PAID ON YOUR FORMER SPOUSE'S BEHALF. IN ADDITION, ALL BENEFITS MAY BE SUSPENDED FOR YOU AND YOUR DEPENDENTS IF SUCH CLAIMS ARE NOT REPAID IMMEDIATELY.

BENEFITS PROVIDED BY THE FUND ARE NOT GUARANTEED. THE TRUSTEES RESERVE THE RIGHT, IN THEIR SOLE DISCRETION AND AT ANY TIME, TO CHANGE OR DISCONTINUE (1) THE TYPES AND AMOUNTS OF BENEFITS UNDER THIS FUND, AND/OR (2) THE ELIGIBILITY RULES, INCLUDING THOSE RULES PROVIDING EXTENDED OR ACCUMULATED ELIGIBILITY AND RETIREE COVERAGE, EVEN IF THE EXTENDED ELIGIBILITY HAS ALREADY BEEN ACCUMULATED OR EARNED.

IT IS EXTREMELY IMPORTANT THAT YOU KEEP THE FUND OFFICE INFORMED OF ANY CHANGE IN ADDRESS, DESIRED CHANGES IN BENEFICIARY, OR INFORMATION REGARDING YOUR DEPENDENTS. THIS IS YOUR OBLIGATION, AND YOU COULD LOSE BENEFITS IF YOU FAIL TO DO SO. THE IMPORTANCE OF A CURRENT, CORRECT ADDRESS AND CURRENT, CORRECT INFORMATION (INCLUDING SOCIAL SECURITY NUMBERS) REGARDING YOUR DEPENDENTS ON FILE IN THE FUND OFFICE CANNOT BE OVERSTATED. IT IS THE ONLY WAY THE TRUSTEES CAN KEEP IN TOUCH WITH YOU REGARDING FUND CHANGES AND OTHER DEVELOPMENTS AFFECTING YOUR INTERESTS UNDER THE FUND.

TABLE OF CONTENTS

DEFINITIONS

When reading this SPD you may encounter some terms with which you may not be familiar or which may have a specific meaning. The following definitions are provided to help you understand what these terms mean and how they are applied. Additional terms may be defined in the relevant sections below.

Alcohol or Substance Abuse: A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Substance can refer to a drug of abuse, a medication, or a toxin.

Anniversary Date: The date your coverage first became effective, or the date a benefit is utilized.

Beneficiary: A person designated by a Participant to receive any life insurance benefits payable under the Fund.

BlueCard® Program & BlueCard Worldwide Program: Coverage for Network, Out-of-Network and worldwide hospitalization and medical coverage.

Board of Trustees or Trustees: The Board of Trustees of the Local 282 Welfare Trust Fund.

Collective Bargaining Agreement(s): The labor agreement(s) between the Union and Contributing Employers requiring contributions to the Fund.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Employment: Work for which an Employer is required to and does make contributions to the Fund pursuant to a Collective Bargaining Agreement.

Custodial Care: All services and supplies, including room and board that are provided primarily to assist a Participant or his/her Dependent in the activities of daily living and which do not require the continuous attention of trained medical or paramedical personnel. Such care may include preparation of special diets, supervision over medication that can be self-administered, or assistance in getting in or out of bed, walking, bathing, dressing, eating or using the toilet. Services and supplies may be deemed to be Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Dependents:

a) In General. Dependents are the legal Spouse and each child under twenty-six (26) years of age of a Participant, except while in military service. "Child" includes natural child, stepchild, adopted child, foster child, and child for whom you are appointed as legal guardian.

b) Dependent also includes a child who is over age 26, provided that the child is a) primarily supported by you **and** b) became Disabled before age 21.

c) Multiple Coverage under the Fund. In the event that both parents are Participants, a child will be considered a Dependent of one of the parents, but not both.

For purposes of this Fund, a "child" includes: a) your biological child; b) your stepchild; c) your legally adopted child from the start of any waiting period prior to the finalization of the child's adoption; d) your legally adopted newborn infant from the date you take physical custody of the child upon the child's release from the Hospital prior to the finalization of the child's adoption; e) a foster child (within the meaning of section 152(f) of the Internal Revenue Code); and f) a child for whom you have been appointed legal guardian.

Deductible: The out-of-pocket expense that you must pay each year before certain benefits are payable under the Fund.

Dentist: A person who is duly licensed to practice dentistry or orthodontics or to perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For purposes of this definition, a Physician will be considered to be a Dentist when he performs any of the dental services described in the Schedule of Benefits set forth in the Dental Expense Benefits portion of this booklet and is operating within the scope of his license.

Disability or Disabled*:* Your inability to perform substantially all of the duties of your occupation in Covered Employment because of a medically determined physical or mental Illness or Injury. For your child, the terms mean that the child is incapable of self-sustaining employment by reason of mental illness, developmental disability, (all as defined in the New York State mental hygiene law) or physical handicap, and provided the incapacitating condition began before age 21.

Eligible Employee: An Employee who has met the eligibility requirements of the Fund or who elected COBRA continuation coverage and submitted timely premium payments.

Employee: A person employed by an Employer in Covered Employment on whose behalf contributions are required to be made and are made to the Fund. An Employee also includes employees of Local 282 and Local 282 Welfare Trust Fund.

Employer or Contributing Employer: Any Employer that is obligated, pursuant to a Collective Bargaining Agreement or Fund participation agreement, to make contributions to the Fund on behalf of its Employees. An Employer also includes Local 282 and Local 282 Welfare Trust Fund.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental: Any medical procedure, equipment, treatment, course of treatment, technique, procedure, drug or medicine that is:

a) meant to investigate and is limited to research;

b) restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;

c) not generally recognized by the medical community, as reflected in the published peer literature as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition; and/or

d) not proven in an objective way to have therapeutic value or benefit for the particular diagnosis or treatment of the covered person's condition.

Government approval of a procedure, equipment, treatment, drug, medicine or technique is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition. Any or all of the following five criteria **may**, within the Trustees' sole and absolute discretion, be applied in determining whether such procedure, etc., is Experimental:

1. Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met.
2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.
3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes (as defined in #3 above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

Fund: The Local 282 Welfare Trust Fund, maintained in accordance with the Amended and Restated Agreement and Declaration of Trust made on September 24, 2012, and amendments thereto (the "Trust Agreement").

Fund Administrator: The statutory Fund Administrator is the Local 282 Welfare Trust Fund Board of Trustees with offices at 2500 Marcus Avenue, Lake Success, New York 11042, (718) 343-3322 or (516) 488-2822.

Fund Office: Local 282 Welfare Trust Fund, 2500 Marcus Avenue, Lake Success, New York 11042, (718) 343-3322 or (516) 488-2822.

Hospital: An institution that: (a) is duly licensed as a hospital (if licensing is required in the state); (b) operates primarily for the diagnosis, treatment and rehabilitation of sick, injured or disabled persons on an inpatient basis at the patient's expense; (c) continuously provides 24-hour-a-day nursing services by or under the supervision of registered graduate nurses on duty or call and is operated continuously with organized facilities for operative surgery; (d) has a staff of one or more duly licensed Physicians available at all times;

(e) provides organized diagnostic and therapeutic facilities for surgical and medical diagnoses either on its premises or at an institution with which the establishment has a formal arrangement for the provision of such facilities; (f) is not primarily a clinic, nursing, rest or convalescent home or an extended care facility or a similar establishment, and (g) has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals. Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or extended care facility is deemed to be confinement in an institution other than a Hospital.

A Hospital that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare is also deemed to be a "Hospital" for purposes of this SPD.

Illness: A sickness, disorder or disease resulting in an unsound condition of the mind or body, including, but not limited to, pregnancy, childbirth and related conditions.

Industry Plan of Benefits: The specific plan of benefits (e.g., Plan A, Plan C, Plan D or Retiree coverage) listed on pages 16-19 for which you and your Dependents are eligible.

Injury: A wound or damage sustained accidentally and by external force.

Maintenance Drugs: Drugs that are prescribed for a long period of time and are necessary to sustain good health. Examples are drugs used to treat high blood pressure, diabetes and arthritis.

Maximum Allowable: For the purpose of determining reimbursements under the Fund, the Maximum Allowable charge for any covered service or supply shall be the amount stipulated by the Board of Trustees as the Maximum Allowable charge for that service or supply. The Maximum Allowable charge is the maximum amount the Fund will pay for charges that are:

- covered under the Fund;
- Medically Necessary; and
- provided in accordance with all applicable preauthorization, medical management programs or other requirements.

The Maximum Allowable charge on our Out-of-Network provider fee schedule has been developed by reference to one or more of several sources, including the following:

- Amounts based on the Blue Cross and Blue Shield Network provider fee schedule/rate;
- Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
- Amounts based on charge, cost reimbursement or utilization data;

- Amounts based on information provided by a third-party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Blue Cross and Blue Shield claims administrator or a third-party vendor which has been agreed to by the provider.

Medically Necessary: Any service, treatment or supply, including a Hospital confinement, furnished or prescribed by a Physician or other licensed provider to identify or treat an Illness or Injury, that:

- is necessary for the diagnosis and treatment of the Illness or Injury for which it is performed;
- is based upon valid medical need;
- meets generally accepted standards of medical practice;
- is required for reasons other than the convenience of the patient or provider; and
- is the most appropriate level of service or supply that can safely be provided for the patient.

The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that they are Medically Necessary.

Medicare: The federal health insurance program for people who are age 65 and certain disabled people who are under age 65, provided under Title XVIII of the Social Security Act of 1965, as amended.

Medicare-Eligible: You or your Dependent, if enrolled in and covered under Medicare or eligible to enroll in and be covered under Medicare.

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

***Network providers, benefits, or services*:** Health care providers in the Anthem Blue Cross and Blue Shield network, or benefits or services received from Network providers.

***Out-of-Network providers, benefits, or services*:** Health care providers not in the Anthem Blue Cross and Blue Shield network, or benefits or services received from Out-of-Network providers.

Other Hospital Services and Supplies: Services and supplies furnished to Participant or Dependent and required by treatment, other than Room and Board, the professional services of any Physician and any private duty or special nursing service (including intensive nursing care by whatever name called).

Participant: An Eligible Employee or an eligible Pensioner.

Physician: A duly licensed doctor of medicine or osteopathy acting within the scope of his or her license. The Fund covers charges for professional medical

services of licensed social workers, chiropractors and professional counselors certified in the state where their practice is located.

Preferred Provider Organization ("PPO"): A group of selected Physicians, and Hospitals, and other treatment centers and providers that have agreed to provide their services to Fund Participants and Dependents under the terms of an agreement.

Qualified Medical Child Support Order ("QMCSO"): A court order for a Participant to provide health benefits or child support related to health benefits.

Room and Board: Room, board, general duty nursing and any other services regularly furnished by a Hospital as a condition of occupancy or the class of accommodations occupied, but not including professional services of Physicians or intensive nursing care by whatever name called.

SPD: This Summary Plan Description.

Spouse: Legal spouse as defined by the law of the state where the marriage took place.

Totally Disabled: As a result of (a) sickness, illness, disease, or (b) injury to your body, or (c) pregnancy, childbirth, or related medical conditions, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, for purposes of the life insurance benefit described in this SPD.

Union: Local 282, International Brotherhood of Teamsters.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994, and regulations thereunder, as amended from time to time.

DOT DRUG TESTING FOR NEWLY-HIRED EMPLOYEES

If you are a newly-hired Employee who has not yet become an Eligible Employee, the Fund will pay for your alcohol and drug testing required by the United States Department of Transportation ("DOT"). The Fund will pay only for testing done by a provider with whom the Fund has contracted, and it will pay only for tests that your Employer requires you to take.

PLAN A
SCHEDULE OF BENEFITS

For Active Eligible Employees and Dependents

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES ONLY*

	Page	
Paid Family Leave	34	
Life Insurance	35	$25,000
Supplemental Life Insurance	36	$ 1,500
Accidental Death & Dismemberment Insurance	37	See schedule
Weekly Accident & Sickness Benefits	42	as per State requirements

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES AND DEPENDENTS

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Comprehensive Major Medical Benefits	50
Hospitalization Benefits	56
Optical Benefits	75
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Prescription Drug Benefits	81
Non-Invasive Cardiac and Vascular Evaluation	84
Employee Assistance Program	85
Annual Diagnostic Examination	86

Coverage for Dependents ceases on the later of (1) twelve months after the last day of the month during which the Participant dies or (2) the date coverage for the Participant would have ended had the Participant not died.

Coverage for Dependents who are children is provided until the end of the month during which the child attains age 26, unless the child is Disabled and Disabled status is submitted to the Fund within 31 days after the child attains age 26.

Coverage may be extended under COBRA, as described on page 29.

*See page 22 for eligibility rules.

PLAN C
SCHEDULE OF BENEFITS

For Active Eligible Employees and Dependents

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES ONLY*

	Page	
Paid Family Leave	34	
Life Insurance	35	$25,000
Supplemental Life Insurance	36	$ 1,500
Accidental Death & Dismemberment Insurance	37	See schedule
Weekly Accident & Sickness Benefits	42	as per State requirements

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES AND DEPENDENTS

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Comprehensive Major Medical Benefits	50
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Coverage for Dependents ceases on the later of (1) twelve months after the last day of the month during which the Participant dies or (2) the date coverage for the Participant would have ended had the Participant not died.

Coverage for eligible children is provided until the end of the month during which the child attains age 26, unless the child is Disabled, and acceptable proof of Disabled status is submitted to the Fund within 31 days after the child attains age 26.

Coverage may be extended under COBRA, as described on page 29.

*See page 22 for eligibility rules.

PLAN D
SCHEDULE OF BENEFITS

For Active Eligible Employees and Dependents

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES ONLY*

	Page	
Paid Family Leave	34	
Life Insurance	35	$10,000
Supplemental Life Insurance	36	$ 1,500
Accidental Death & Dismemberment Insurance	37	See schedule
Weekly Accident & Sickness Benefits	42	as per State requirements

BENEFITS AVAILABLE TO ELIGIBLE EMPLOYEES AND DEPENDENTS

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Dental Benefits	77	*Schedule #5*
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Non-Invasive Cardiac and Vascular Evaluation	84	
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Coverage for Dependents ceases on the later of (1) twelve months after the last day of the month during which the Participant dies or (2) the date coverage for the Participant would have ended had the Participant not died.

Coverage for eligible children is provided until the end of the month during which the child attains age 26, unless the child is Disabled, and acceptable proof of Disabled status is submitted to the Fund within 31 days after the child attains age 26.

Coverage may be extended under COBRA, as described on page 29.

*See page 22 for eligibility rules.

SCHEDULE OF PENSIONER BENEFITS

For Service Pensioners (with at least 25 years of Pension Credit) who retire under the provisions of the Local 282 Pension Trust Fund from the following industries or Employers:

Building Material Contractors	**Building Material Suppliers (Tier 1)**
Compressed Gas	**Demolition**
High Rise	**Heavy Construction/Asphalt Excavating (NYC-N/S)**
Lumber (Tier 1)	**Local 282 I.B.T. & Trust Funds**
Mechanical Trades (25/55)	**Mobile Office Trailer**
Plumbing Supply (25/55)	**Ready Mix (NYC-N/S)**
Raw Equipment (Tier 1)	**Tool Supply – Hilti Inc.**
Sand & Gravel	

PENSIONERS & DEPENDENTS UNDER AGE 65

	Page	
Comprehensive Major Medical Benefits	50	*Anthem Blue Cross*
Hospitalization Benefits	56	
Optical Benefits	75	
Prescription Drug Benefits	81	*$4,000 maximum payable per family, per calendar year followed by an 80/20% co-insurance benefit*
Non-Invasive Cardiac and Vascular Evaluation	84	
Employee Assistance Program	85	
Annual Diagnostic Examination	86	

Coverage for Dependents ceases twelve months after the last day of the month during which a Pensioner dies (i.e., if a Pensioner dies on April 5, 2020, coverage for Dependents will cease April 30, 2021 subject to COBRA as described on page 29).

Coverage may be extended under COBRA, as described on page 29.

PENSIONERS AND DEPENDENTS OVER AGE 65 OR UNDER AGE 65 WHO ARE ELIGIBLE FOR MEDICARE BENEFITS

For Pensioners and Dependents age 65 and over or under age 65 who are eligible for Medicare (for example, due to disability) and have Pensioner Benefits.

Hospitalization and Major Medical benefits will be provided by United America, as a supplement to Medicare. This Fund will be secondary to Medicare for a retired Participant or the Dependent of a retired Participant, who is age 65 or older. This Fund will also be secondary to Medicare for a retired Participant or the Dependent of a retired Participant who is found to be disabled by the Social Security Administration under age 65 and becomes eligible for Medicare before the age of 65. If you or your Dependents are eligible under this Fund and Medicare, Medicare will reimburse charges first. Through an arrangement with Medicare, following payment by Medicare, your claim will automatically be sent to United America for consideration and payment of any supplemental amounts due. **YOU DO NOT NEED TO SUBMIT YOUR OWN CLAIM TO United America**. This Fund pays the difference between Medicare's Allowable Charge and the amount paid by Medicare. Combined payments under Medicare and this Fund will not exceed Medicare's Allowable Charge.

It is important to note that this Fund will pay benefits as if you are covered for all Medicare Part A and Part B benefits for which you would be eligible regardless of whether you registered or enrolled in Medicare. Also, if the Fund pays more than it should have, the Fund has the right to recover the excess amount from the party who received the payment. See page 46 Fund's Subrogation and Restitution Obligation.

Coverage for Dependents ceases twelve months after the last day of the month during which a Pensioner dies (i.e., if a Pensioner dies on April 5, 2020, coverage for Dependents will cease April 30, 2021 subject to COBRA as described on page 29).

Eligible Pensioners and/or Dependents will be reimbursed $109 (per month subject to change at the Trustees' discretion) for Medicare Part B coverage at the end of each calendar quarter. Note that this reimbursement amount is lower than the standard Medicare Part B monthly premium, which was $135.50 as of January 1, 2019.

If you or your Spouse becomes disabled after your Retirement, you must notify the Fund Office and accept both Part A and Part B of Medicare. If you do not elect Medicare Part A and Part B at that time, you may be subject to a late payment enrollment penalty by Medicare, which will not be reimbursed by the Fund.

SCHEDULE OF BENEFITS

For Active Eligible Employees and/or Dependents
Who Are Eligible for Medicare Benefits

ALL INDUSTRIES

If you are actively employed, Medicare does not automatically become primarily responsible for your hospital, medical and surgical claims when you are age 65 or older. Your coverage for all of the benefits provided by the Fund will be continued under the Schedule of Benefits for your particular Employer/Industry as long as you remain an Eligible Employee under the rules set forth in this SPD, regardless of your age. Medicare will, in many cases, pay all or a part of the portion of the bill that the Fund does not pay, if you have enrolled in Medicare. However, you have the right, under law, to have Medicare assume full responsibility for your claims. But if you do so, the law does not allow the Fund to pay **any** portion of the bill that Medicare does not pay, unless it is for benefits not covered under Medicare, such as vision care.

In choosing whether the Fund or Medicare should provide primary coverage for your health claims, please consider the following:

- If you select Medicare as your primary insurer while you are still actively employed, neither the Fund nor your Employer is permitted by law to provide you with any additional coverage for medical or surgical claims. This means that Medicare would then be **your only source** for covering medical and surgical costs, other than any supplemental plan you may purchase at your own expense. Any expense that is in excess of what Medicare allows would then be an out-of-pocket expense to you, unless reimbursable under a Medicare supplemental plan you may purchase.
- If you select the Fund as your primary health coverage, your medical, and surgical and prescription drug claims will be submitted first to the Fund for payment based on the coverage and allowances provided through the Fund. If there is any balance remaining, the claim may then be submitted to Medicare as the secondary insurer for payment up to the amount allowed through Medicare. The Fund will also be primary for your Spouse as long as you are actively employed, regardless of your Spouse's age.

While practically everyone becomes eligible for Medicare once they reach age 65, you are not automatically enrolled in Medicare unless you have filed an application and established entitlement to a monthly Social Security Benefit.

Those Participants who are approaching age 65 who have not or do not intend to file for Social Security Benefits, should file an application with Medicare during the three-month period prior to the month in which they reach age 65, in order for Medicare coverage to be effective the first day of the month in which they attain age 65, regardless of whether they intend the Medicare coverage to be primary or secondary.

MEDICARE BENEFITS DUE TO TOTAL DISABILITY

You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability, as defined by Medicare, or end stage renal disease (ESRD). The following rules apply with respect to coordination of benefits with Medicare due to total disability or ESRD prior to age 65. Upon attainment of age 65, the rules for coordination of benefits and Medicare at age 65 (described on preceding pages) will apply.

If, while you are actively employed, you or any of your covered Dependents becomes covered by Medicare because of ESRD, this Fund pays first and Medicare pays second for 30 months starting on the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Fund pays second.

If you or a covered Dependent becomes eligible for Medicare due to a disability, and are eligible for Fund coverage as well, Medicare will pay second.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

In general, an Employee will initially become eligible for coverage under the Fund after satisfying the basic 200-hour work rule, as specified in the section below entitled "**Eligibility Rules For Employees Who are Not One Hundred Percent Owners"**.

An Employee who, alone or with his or her Spouse, owns one hundred percent (100%) of a Contributing Employer will become eligible for coverage after complying with the 425-hour work rule, as specified in the section below entitled "**Eligibility Rules for One Hundred Percent Owners"**.

A feature of the eligibility rules is the provision for a "skip" month. This means that one (1) month separates the employment (or determination) quarter or 12-month period from the applicable benefit coverage (or eligibility) quarter or 12-month period. The employment quarter or 12-month period consists of the months in which hours worked are counted for eligibility. The coverage quarter or 12-month period consists of the months during which health coverage is provided.

The benefit coverage (or eligibility) quarters start on the following dates: *March 1, June 1, September 1, and December 1*. The applicable employment (or determination) quarters start on the following dates: November 1, February 1, May 1 and August 1. The benefit coverage (or eligibility) period for a "floating quarter" of coverage, as described in more detail below, commences on March 1 with the applicable employment (or determination) period the prior February 1-January 31 period.

ELIGIBILITY RULES FOR EMPLOYEES WHO ARE NOT ONE HUNDRED PERCENT OWNERS

1. Employees who work 200 hours or more in Covered Employment in an employment quarter for which contributions are received by the Fund will be covered for full benefits, including full accident and sickness benefits, in the next benefit coverage quarter.

2. Employees who work for at least one hour but fewer than 200 hours in Covered Employment in an employment quarter for which contributions are received by the Fund will be covered **ONLY** for (a) weekly accident and sickness benefits in the next benefit coverage quarter and (b) to extent the Employee is otherwise eligible, paid family leave benefits and Vacation and Sick Leave benefits. Thereafter, Employees must work at least 200 hours in Covered Employment in an employment quarter for which contributions are received by the Fund to be covered for full benefits in the next benefit coverage quarter.
3. Employees who work 1,000 hours or more in Covered Employment during the twelve-month period commencing on February 1 and ending on January 31 for which contributions are received by the Fund will be eligible for one "floating" quarter of coverage in the twelve-month period commencing on the subsequent March 1 and ending on the next February 28th or 29th. This "floating" quarter of coverage will be available for any eligibility quarter that starts in the subsequent 12-month period.
4. For example, suppose an Employee works 200 hours per month in Covered Employment starting on February 1, 2020. The employee will have worked 1,000 hours by the end of June, 2020. If the Employee does not work for 200 hours in the employment quarter that begins on November 1, 2020, the Employee will still be able to elect coverage for the quarter that begins on March 1, 2021. However, to be eligible for coverage for the quarter that begins on June 1, 2021, the Employee will need to work 200 hours in Covered Employment during the employment quarter that begins on February 1, 2021.

Employees who are covered by a Collective Bargaining Agreement requiring hourly vacation accrual and pay (whether directly from the Employer or from the Fund), as described below under Vacation and Sick Leave Benefits, will be deemed to have worked an additional 8 hours in Covered Employment for every 120 hours reported on their behalf.

Please note that you can only be credited for hours after your Employer has submitted the required remittance report and contributions on your behalf to the Fund for each applicable period. Any claims submitted while your Employer is delinquent in the payment of contributions will not be paid until your Employer makes the payments due for the relevant period in accordance with the Collective Bargaining Agreement and the rules of the Fund.

ELIGIBILITY RULES FOR ONE HUNDRED PERCENT OWNERS

An Employee who, alone or with his or her Spouse, or whose spouse alone owns one hundred percent (100%) of a Contributing Employer, will become eligible for coverage as follows:

1. One Hundred Percent Owners who work 425 hours or more in an employment quarter in Covered Employment for which contributions are received by the Fund will be eligible for full benefits, including accident and sickness benefits, in the applicable benefit coverage quarter.

2. One Hundred Percent Owners who work at least one hour but less than 425 hours in an employment quarter in Covered Employment for which contributions are received by the Fund will be covered **ONLY** for (a) weekly accident and sickness benefits in the next benefit coverage quarter and, to the extent the One Hundred Percent Owner is eligible, (b) paid family leave benefits. Thereafter, One Hundred Percent Owners must work the required hours in an employment quarter, for which contributions are received, as set forth in Paragraph (1) above, to be covered in the applicable benefit coverage quarter.
3. One Hundred Percent Owners who work 1,700 hours or more in Covered Employment during the twelve-month period commencing on February 1 and ending on January 31 for which contributions are received by the Fund will be eligible for one "floating" quarter of coverage in the twelve-month period commencing on the subsequent March 1 and ending on the next February 28th or 29th. This "floating" quarter of coverage will be available for any eligibility quarter that starts in the subsequent 12-month period.
4. For example, suppose a One Hundred Percent Owner works 425 hours per quarter in Covered Employment starting on February 1, 2020. The employee will have worked 1,700 hours by the end of May, 2020. If the Employee does not work for 425 hours in the employment quarter that begins on November 1, 2020, the Employee will still be able to elect coverage for the quarter that begins on March 1, 2021. However, to be eligible for coverage for the quarter that begins on June 1, 2021, the Employee will need to work 425 hours in Covered Employment during the employment quarter that begins on February 1, 2021.

Please note that you can only be credited for hours after your Employer has submitted the required remittance report and contributions on your behalf to the Fund for each month. Any claims submitted while your Employer is delinquent in the payment of contributions will not be paid until your Employer makes the payments due in accordance with the Collective Bargaining Agreement and the rules of the Fund.

DISABILITY CREDIT

If an Employee becomes Disabled and receives either the Fund's weekly accident and sickness benefit for off-the-job Injury/Illness or workers' compensation benefits for Injury/occupational Illness sustained while working for an Employer, he/she will continue to have hours credited towards his/her eligibility, provided that:

- he/she was continuously covered during the four benefit coverage quarters prior to the benefit coverage quarter in which he/she became Disabled, and
- his/her Disability last 29 days or longer.

You will be credited with a maximum of 16 hours per week for each week of either weekly accident and sickness or Workers' Compensation benefits, up to 26 weeks for a non-job-related Injury and 104 weeks for a job-related Injury or occupational Illness.

Hours credited under this provision will be used for credit toward the Fund's annual eligibility rule. However, you will not be given credit hours for any period after your Welfare Trust Fund eligibility has been terminated. Thus, for example, your benefits cannot be reinstated after a period of ineligibility for continuous Welfare Trust Fund coverage.

In addition to the above, an Employee who is receiving Workers' Compensation benefits will continue to receive the credit indicated above provided:

- the Employee is continuing to receive payments from the Workers' Compensation Insurance carrier;
- the Employee has not received any earnings whatsoever as a result of Covered Employment; and
- the Employee is not receiving a pension from the Local 282 Pension Trust Fund.

NOTE: Charges covered by Workers' Compensation will not be covered by the Fund.

PARTICIPANTS RECEIVING WORKERS' COMPENSATION BENEFITS MUST NOTIFY THE FUND OFFICE IMMEDIATELY SO THAT COVERAGE MAY BE CONTINUED FOR THE PERIOD PERMITTED.

PENSIONER ELIGIBILITY

An Employee covered by Plan A who retires on a Service Pension from the Local 282 Pension Trust Fund from employment with a Plan A Employer may be eligible for Welfare Trust Fund benefits under the Pensioner Schedule of Benefits, set forth on page 19. Please refer to the Summary Plan Description of the Local 282 Pension Trust Fund for the definition of a Service Pension.

You must inform the Fund if you engage in in disqualifying employment as defined in the Local 282 Pension Plan ("Disqualifying Employment"). If your Service Pension is suspended by the Local 282 Pension Trust Fund due to your having engaged in Disqualifying Employment, your Pensioner Benefits under this Fund will be suspended beginning when you become eligible for coverage due to your Covered Employment and continuing for as long as you remain in Covered Employment. **In addition, your failure to inform this Fund about Disqualifying Employment you engaged in is a material misrepresentation under the Fraud section of this SPD (see page 49) and may result in your coverage being terminated retroactively.**

CONDITIONS UNDER WHICH YOUR COVERAGE TERMINATES

If you are eligible for coverage based upon the Fund's "quarterly eligibility rule", your coverage terminates if you work less than 200 hours (or 425 hours, for One Hundred Percent Owners) in Covered Employment in an employment quarter for which contributions are received by the Fund. Coverage will terminate on the last day of the first month of the subsequent benefit coverage quarter, unless you are eligible, and elect coverage for, an additional quarter based on the Fund's "1,000-hour" eligibility rule. If you receive an additional quarter of coverage due to the 1,000-hour rule, your coverage will terminate at the end of the additional benefit coverage quarter unless you have worked another 200 hours in Covered Employment in the relevant employment quarter. See the

section on COBRA continuation for information about how you can continue coverage following termination of eligibility based on hours worked.

The only exceptions to these termination rules are those made because of Disability, as explained under the "Disability Credit" section (see page 24).

Coverage may also terminate for reasons described elsewhere in this SPD, for example, if the Trustees terminate the Fund or if you engage in Disqualifying Employment, as described above, or if you commit Fraud as defined in this SPD.

EXTENDED MEDICAL BENEFITS AFTER COVERAGE TERMINATES

Under the following limited conditions, the Hospital and medical/surgical benefits with respect to an particular Injury or illness, or with respect to a pregnancy, will continue for the calendar year in which the coverage terminates and during the next calendar year, provided that no other coverage (must provide evidence) is in effect:

- An Injury or illness causing continuous total Disability from such termination date, or
- Until that Injury or illness ends, or
- A pregnancy existing at such termination date as evidenced by a written statement of the attending Physician.

SPECIAL CIRCUMSTANCES

MILITARY DUTY IN THE UNITED STATES ARMED FORCES

The USERRA requires that the Fund offer continuous health coverage for up to twenty-four (24) months, beginning on the date on which the Participant's absence begins, to Participants who are absent from employment, whether voluntarily or involuntarily, due to military or uniformed service, as that service is defined by USERRA, including Reserve and National Guard Duty and certain types of services in the National Disaster Medical System, as described below.

Participants who are absent from employment by reason of service in the uniformed services can elect to continue coverage for themselves and their Dependents under the provisions of USERRA. The period of coverage for the Participant and Dependents while the Participant is in the military ends on the earlier of:

a) The end of the twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

b) the day after the date on which the Participant is required to but fails to apply for or return to a position of employment. (For example, for periods of service over one hundred eighty (180) days, generally the person must reapply for employment within ninety (90) days of discharge.)

You may be required to pay all or a portion of the cost of your benefits under the Fund. If your military service lasts thirty-one (31) days or less, there is no charge for this coverage beyond the normal Deductible or co-payments you would pay if you were employed. If your military service extends more than

thirty-one (31) days, you must pay the cost to continue coverage under the Fund, in accordance with the provisions of USERRA.

You must notify your Contributing Employer that you will be absent from employment due to military service unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. You also must notify the Fund if you wish to elect continuation coverage for yourself or your Dependents under the provisions of USERRA. If you satisfy the Fund's eligibility requirements at the time you entered the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Fund when you return from uniformed service except in the case of certain service-connected disabilities, provided you return to your last employer within the required time period. Protection under USERRA can be lost due to a dishonorable discharge, a bad conduct discharge, or discharge other than honorable discharge. Contact the Fund Office or your Employer for further details regarding your rights and obligations under USERRA.

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you meet the requirements of the Family and Medical Leave Act (FMLA), you may be entitled to up to 12 weeks of unpaid leave for specified family or medical purposes. The reasons include the birth or adoption of a child, providing care for a Spouse, child or parent who is seriously ill, or for your own serious Illness. The FMLA provides that you can continue your coverage under the Fund during that leave period, to a maximum of 12 weeks. Your Employer is required to continue to pay contributions for your continued coverage under the Fund during the period of your FMLA leave.

You may also be entitled to up to a maximum of 12 weeks of unpaid leave because of a "qualifying exigency" (as defined in Department of Labor Regulations) arising out of the fact that your Spouse, son, daughter or parent is on active duty, or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation. (If you believe you are entitled to leave due to a "qualifying exigency," you should contact your Employer.)

In addition, the FMLA permits a Spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave (including any other FMLA leave in the same 12-month period) to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or Illness.

Check with your Employer to determine whether your Employer is subject to the FMLA and whether the leave you wish to take is covered by the FMLA. Questions regarding your entitlement to FMLA leave should be referred to your Employer. **Your Employer has an obligation to continue your coverage under this Fund during a leave of absence that is covered by the FMLA**. In order to continue your Fund coverage, your Employer must continue to make contributions on your behalf for any period that you are on approved FMLA leave. Please contact the Fund Office if you intend to take FMLA leave so that we are aware of your Employer's obligation to make contributions during your

absence. Note that if you do not return to work after your FMLA leave ends, you may be required to repay the amount your Employer paid to the Fund for your coverage while on leave. You may, however, be entitled to continue your coverage under the COBRA Continuation Coverage provisions set forth on pages 29-34 of this SPD.

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE NEW YORK PAID FAMILY LEAVE LAW

The New York Paid Family Leave Law requires employers to maintain existing health benefits for an employee on qualified paid family leave as if the employee had continued to work during the leave. For every hour you use paid family leave, your Employer must report and pay to the Fund the required contributions under the CBA as if you were actively working. For example, if you take forty (40) hours of paid family leave during a week, your Employer should report and pay 40 hours to the Fund. If you work fifteen (15) hours during a week and take twenty-five (25) hours of paid family leave during the same week, your Employer should report and pay on 15 hours to all of the relevant Local 282 benefit trust funds and 25 hours to this Fund only.

For a description of income replacement benefits available to you under the New York Paid Family Leave Law, see page 34.

DEPENDENT ELIGIBILITY

Your Dependents are eligible for Fund coverage during all periods when you are covered by the Fund.

Coverage for newborn children of Participants will terminate unless copies of the newborn's birth certificate and Social Security card are provided to the Fund Office within 30 days of the birth of the newborn.

Children born to Dependents are only covered under the Participant's coverage for 30 days from birth.

WHEN DOES COVERAGE FOR DEPENDENTS BEGIN?

Each of your Dependents will be covered on the date you become covered or the date they become a Dependent (or documentation is provided of their birth, adoption or marriage), as defined herein, whichever is later. Benefits are available to your Dependents for services rendered on or after the effective date of your Dependent's eligibility for coverage.

WHEN DOES COVERAGE FOR DEPENDENTS END?

Coverage for your Dependents terminates when your coverage terminates or when the individual no longer meets the definition of a Dependent, as set forth above. Coverage for your Spouse ends on the date of divorce. For all benefits, a child (other than a child who is Disabled) who attains 26 years of age shall cease to be a Dependent as of the last day of the month in which such age is attained.

Additional events that may lead to ineligibility and loss of coverage under the Fund include, but are not limited to:

1. Deliberate failure to report a divorce;
2. Deliberate failure to timely pay any required COBRA premiums;

3. Termination of the Fund by the Trustees;
4. Your commission of Fraud, as defined in this SPD.

If you do not timely notify the Fund Office of an event that causes a loss of your or your Dependent's eligibility under the Fund, and that failure to notify is determined to be willful or fraudulent, you may be required to reimburse the Fund for benefits that were paid after the event that caused the coverage to terminate, subject to the limitations of the Patient Protection and Affordable Care Act (PPACA).

If a Participant dies, coverage for the Participant's Dependents will cease twelve months after the last day of the month during which the Participant dies.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If a court or state administrative agency has issued an order with respect to health care coverage for your child(ren), the Trustees or their designee shall determine if the order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law. The Plan will notify both parents of the receipt of the order and advise them of the Plan's procedures that must be followed to provide coverage of the child(ren) covered by the order. However, no coverage will be provided for any child pursuant to a QMCSO unless all of the Plan's requirements for coverage of that child have been satisfied. The Fund will provide coverage to a child under a QMCSO even if the Participant does not have legal custody of the child. If the Fund receives a QMSCO and if the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You may obtain a copy of the Fund's QMCSO procedures at no charge by submitting a written request to the Fund Office.

CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, provides that Eligible Employees and/or their Dependents can continue Fund coverage on a temporary basis in certain instances when coverage under the Fund would otherwise end. In order to continue Fund coverage under COBRA, you and/or your Dependents are required to pay the full cost for such coverage during the continuation period. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

DECIDING WHETHER TO ELECT COBRA CONTINUATION COVERAGE

In deciding whether to elect COBRA continuation coverage, there are a number of considerations that you should take into account, including:

- Whether you will have the right to enroll in other available 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 monthly premiums and lower out-of-pocket costs. Additionally, when you lose coverage under the Fund, 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; and

- The cost, scope and level of COBRA continuation coverage under this Fund compared with that of any other available coverage.

If you are or expect to be covered by another employer-sponsored group health plan (including a plan sponsored by your Spouse's employer), federal law guarantees you certain rights under that plan which you should consider when deciding whether or not to elect COBRA.

Note that being eligible for COBRA under this Fund does not limit your eligibility for coverage for a tax credit through the Marketplace if you elect to buy coverage through the Marketplace.

The Internal Revenue Service (IRS) has issued Notice 98-12 in question and answer format to assist Employees and their families in determining whether to elect COBRA coverage. These questions and answers are available on the IRS internet site (www.irs.ustreas.gov) and at the U.S. Department of Labor (DOL) internet site (www.dol.gov.ebsa).

If your coverage is terminated due to your retirement from employment and you are receiving a pension from the Local 282 Pension Trust Fund, you and your Dependents may be entitled to continued coverage from this Fund under a specific Schedule of Benefits at no cost to you. See page 19 for details.

QUALIFYING EVENTS

COBRA continuation coverage is available if you, your Spouse, and/or child(ren) lose coverage under the Fund as a result of a "Qualifying Event."

For Eligible Employees, a Qualifying Event occurs when you lose coverage under the Fund because of a reduction in your hours of employment (including if you fail to work sufficient hours in a designated work period necessary to maintain Fund eligibility) or the termination of your employment, except if it is because of your gross misconduct.

For an Employee's Spouse who is covered by the Fund, a Qualifying Event occurs when the Spouse loses coverage under the Fund as a result of any of the following events:

- the death of the Employee, following the period of extended Dependent coverage described starting on page 28;
- termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours;
- divorce from the Employee;
- the Employee becomes entitled to Medicare while enrolled in COBRA.

For an Employee's child who is covered by the Fund, a Qualifying Event occurs when the child loses coverage under the Fund as a result of any of the following events:

- the death of the Employee, following the period of extended Dependent coverage described starting on page 28;
- the termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours;

- the divorce of the child's parent from the Participant;
- the Employee becomes eligible for Medicare while enrolled in COBRA;
- the child turns age 26, or otherwise ceases to be a Dependent within the meaning of this SPD.

NOTIFYING THE FUND OF A QUALIFYING EVENT

In order for a Spouse or child to be entitled to continue coverage, the Employee, Spouse or child must notify the Fund Office of:

- The divorce from the Employee; or
- The child's ceasing to be a Dependent as defined.

While the Employer is required to notify the Fund Office of an Employee's termination of employment, reduction in work hours, entitlement to Medicare, or death, it is the family's responsibility to alert the Fund Office of the Employee's divorce or loss of dependent status, and of any Qualifying Event that occurs while you are on COBRA continuation coverage following the Employee's loss of employment. If you get divorced and you or your former Spouse fail to notify the Fund office of your divorce within 60 days, you and/or your former Spouse will be held liable for any and all claims paid on your former Spouse's behalf. In addition, all benefits may be suspended for you and your Dependents if the wrongful benefits are not repaid immediately.

NOTICE THAT YOU OR YOUR DEPENDENT(S) ARE ENTITLED TO CONTINUATION COVERAGE

When the Fund Office is notified on a timely basis of the occurrence of a Qualifying Event, you and/or your Dependent(s) will be notified that you and/or they have the right to continue coverage under the Fund. You and/or your Dependent(s) will then have 60 days to elect COBRA continuation coverage. If you and/or they do not elect COBRA coverage within that time, coverage will end as of the date coverage is lost due to the Qualifying Event in accordance with the Fund's termination rules set forth on pages 28-29.

COVERAGE THAT WILL BE PROVIDED IF YOU ELECT CONTINUATION COVERAGE

If you and/or your Dependent(s) elect COBRA continuation coverage, the Fund is required to provide coverage that is identical to the current coverage that is provided for similarly situated Employees or Dependents. If, during the period of COBRA continuation coverage, the Fund's benefits change for active Employees, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA.

COBRA continuation coverage may consist of either all of the health benefits you and your Dependents were entitled to under this Fund before the Qualifying Event(s) or only the core health benefits you were entitled to under this Fund except optical and dental.

COBRA continuation coverage does not include life insurance, accidental death and dismemberment and/or accident and sickness benefits. You may, however, convert your group life insurance to a direct payment policy through the Standard Life Insurance Company of New York. The time for conversion is limited. Contact the Fund Office for additional information.

ADDITION OF NEW DEPENDENTS WHILE ON COBRA CONTINUATION COVERAGE

If, while you are enrolled in COBRA continuation coverage, you marry, have a newborn child, adopt a child or have a child placed with you for adoption or legal guardianship, that Spouse or child may be enrolled for coverage for the balance of the period of your COBRA continuation coverage on the same terms available to active Employees as long as you notify the Fund Office within 60 days of when you acquire the new Dependent.

WHEN THE MAXIMUM PERIOD OF CONTINUATION COVERAGE MAY CHANGE

Multiple Qualifying Events

If your COBRA continuation coverage (according to the table on the next page) is for a maximum period of 18 months, and during that period, another Qualifying Event takes place that would otherwise entitle a Spouse or child to a 36-month period of COBRA continuation coverage (according to the table on the next page), the 18-month period will be extended for that Spouse or child. The total period of COBRA continuation coverage for any Spouse or child will never exceed 36 months from the date of the **first** qualifying event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your covered Spouse and/or child(ren), and died during that 18-month period, the continuation coverage for your Spouse and/or child(ren) could be extended until 36 months from the date your eligibility would have terminated as a result of your termination of employment.

ENTITLEMENT TO SOCIAL SECURITY DISABILITY INCOME BENEFITS

If before or during the first 60 days of an 18-month period of COBRA continuation coverage, the Social Security Administration (SSA) makes a formal determination that you or a covered Spouse or child is entitled to Social Security Disability benefits, the 18-month maximum period of COBRA continuation coverage can be extended for up to 11 months (for a total of 29 months) for all Qualified Beneficiaries who have elected COBRA continuation coverage. This extension is available only if:

- you or another family member notifies the Fund Office of the SSA determination within 60 days after the determination letter was received; and
- the notice is received by the Fund prior to the expiration of the 18-month COBRA continuation period.

The extended period of COBRA continuation coverage will end if the Social Security Administration determines that you are not disabled. You are required to notify the Fund Office if you are determined not to be disabled.

MAXIMUM PERIOD OF CONTINUATION COVERAGE

The maximum duration of continuation coverage varies based upon the nature of the Qualifying Event and the person losing coverage. The coverage period starts as of the date you lose coverage due to a Qualifying Event. The following chart sets forth the maximum duration of continuation coverage available:

Qualifying Event	Employee	Spouse	Child(ren)
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced	N/A	36 months	36 months
Employee becomes entitled to Medicare while enrolled under COBRA	N/A	36 months from original COBRA coverage start	36 months from original COBRA coverage start
Employee or Dependent is disabled at start of 18-month COBRA period or within first 60 days of COBRA coverage	29 months	29 months	29 months
Dependent child ceases to have Dependent status	N/A	N/A	36 months

WHAT YOU MUST PAY FOR COBRA CONTINUATION COVERAGE

You, your covered Spouse and/or your covered child(ren) will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, if COBRA continuation coverage is extended due to disability as described above and the disabled person has elected COBRA continuation coverage, the cost will be 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage.

The amount you, your Spouse and/or your child(ren) must pay for COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due starting with the date continuation coverage was elected. Subsequent monthly payments will be due on the first day of the calendar month for which coverage is provided. There will be a grace period of 30 days to pay the subsequent monthly payments. While payment within the grace period will maintain your coverage, no claims incurred in a month will be paid until the COBRA payment for that month is received. During the time that the Fund is waiting for payment, COBRA continuation coverage will be confirmed, but providers who inquire will be notified that the cost of the COBRA continuation coverage has not yet been paid and that no claims will be paid until the COBRA payment is made. If payment of the amounts due is not received by the end of the applicable grace period, any COBRA continuation coverage will terminate, and you will be responsible for the charges for any services rendered during that period.

The Fund does not send monthly bills for COBRA. It is your responsibility to pay COBRA payments on a timely basis. If the COBRA payment is not received by the due dates set forth above (including any applicable grace period), coverage will automatically terminate as of the end of the period for which the last COBRA premium was paid. Once COBRA continuation coverage is terminated, it cannot be reinstated.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage may be terminated if:

- the Local 282 Welfare Trust Fund no longer provides any group health coverage or the Fund is terminated;
- you do not pay the applicable premium for your COBRA continuation coverage on time;
- the covered person, after electing COBRA continuation coverage, becomes entitled to Medicare;
- the covered person, after electing COBRA continuation coverage, becomes covered under another group employer health plan; or
- for the 11-month disability extension period described above, the covered person is no longer deemed to be disabled by SSA.

If any covered person enrolls in Medicare after electing COBRA continuation coverage, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any covered Spouse or child of that covered person will not be affected.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

PAID FAMILY LEAVE BENEFITS

State laws have been adopted in both New York and New Jersey to provide workers with paid family leave benefits. The laws in each state have different benefit levels and eligibility requirements, and unique administrative and operating features.

Family leave benefits under the New York State Paid Family Leave Law should contact Standard Life Insurance Company of New York ("Standard"). Plan participants wishing to apply for such benefits should contact Standard at 1-888-937-4783.

You can find more information about the New York State Paid Family Leave Law at: https://ny.gov/programs/new-york-state-paid-family-leave.

Plan participants seeking family leave benefits in New Jersey apply for family benefits directly with the State. Information about the New Jersey law generally, and the application process specifically, can be found at: https://myleavebenefits.nj.gov/worker/fli.

LIFE INSURANCE BENEFITS

This Fund's life insurance benefits are provided through The Standard Life Insurance Company of New York ("The Standard"). The following summarizes the terms of the life insurance benefit. For more detailed information, see the Group Life Insurance Policy document from The Standard, which is available upon request from the Fund Office.

All active Eligible Employees are eligible for life insurance benefits, but the amount of coverage varies depending on which Industry Plan of Benefits you are covered by. The amount of life insurance shown in the Schedule of Benefits for your Industry Plan of Benefits is payable in the event of the death of an Eligible Employee. Payment will be made to the person or persons named by the Participant as Beneficiary in accordance with the terms of the policy.

ACCELERATED BENEFIT

If you are not expected to live more than 12 months due to illness, you can receive, while you are still alive, up to 80% of the life insurance benefit available to you otherwise on your death, unless your insurance is scheduled to end within 12 months following the date you apply for the accelerated benefit. Applications for the accelerated benefit may be submitted to The Standard or to the Fund Office and must include a physician's statement that you are terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months. In addition, you may be required to submit to medical examination by physicians selected by The Standard. The amount of your life insurance after payment of the accelerated benefit will be the difference between the amount that would otherwise be payable on your death and the amount of the accelerated benefit you received.

The accelerated benefit is not available if:

1. All or part of your insurance must be paid to your child(ren) or Spouse or former Spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
2. You are married and live in a community property state, unless you give The Standard a signed written consent from your Spouse.
3. You have made an assignment of your Insurance, unless you give The Standard a signed written consent from the assignee.
4. You have filed for bankruptcy, unless you give us written approval from the Bankruptcy Court for payment of the accelerated benefit.
5. You are required by a government agency to use the accelerated benefit to apply for, receive or continue a government benefit or entitlement.
6. You have previously received an accelerated benefit under The Standard insurance policy.

CHANGE OF BENEFICIARY

You may change your Beneficiary at any time by obtaining a Change of Beneficiary Form from the Fund Office. The change in Beneficiary will not be effective until the Fund Office has received the completed Change of Beneficiary Form.

A Change of Beneficiary Form is the only way you can change your Beneficiary. For example, if you get divorced and your former Spouse is designated as your Beneficiary, you will still need to submit a Change of Beneficiary Form if you want to change the designation; your divorce will not automatically change your beneficiary.

HOW TO CLAIM BENEFITS

Submit an official copy of the Participant's death certificate to the Fund Office. The life insurance benefit will be paid in full to the person or persons named as Beneficiary promptly upon receipt of satisfactory proof of death. If the Beneficiary predeceases the Participant or if the Participant does not name a Beneficiary, the benefit shall be paid to the following persons, if then living, in the following order of priority:

1. The Participant's surviving Spouse
2. The Participant's children
3. The Participant's parents
4. The Participant's brothers and sisters
5. The Participant's estate

TOTAL DISABILITY - CONTINUATION OF LIFE INSURANCE BENEFITS

If, while insured, after being Totally Disabled (as determined by The Standard) for 180 days, you submit to The Standard proof that such Total Disability commenced while you were insured and before you attained age 60, your life insurance coverage will continue from year to year during the continuance of your Total Disability until you reach age 65. Proof must be submitted within 12 months from the date you became Totally Disabled, or as soon as reasonably possible. The Standard may have you examined at its expense, by a physician it chooses, at reasonable intervals, and may discontinue your life insurance if you fail to be examined. Life insurance benefits will continue on account of Total Disability even if you receive an accelerated benefit, as described above, prior to age 60, for as long as you have an illness or physical condition which is reasonably expected to result in death within 12 months, or until you reach age 65.

COVERAGE AFTER YOU LOSE ELIGIBILITY

In the event of termination of your Fund coverage, The Standard may permit you to continue your life insurance without physical examination or other evidence of insurability, either by converting to individual coverage or by buying portable group insurance coverage, provided that you submit a written application to The Standard and pay the first premium within 31 days after termination of insurance coverage under this Fund. The Standard will notify you of your options.

SUPPLEMENTAL LIFE INSURANCE

A supplemental life insurance benefit of $1,500 is available to:

- an active Eligible Employee who was covered by the Fund at any time within the 12-month period immediately preceding his death;
- a Pensioner under the Local 282 Pension Trust Fund, other than a Vested Pensioner, who is not entitled to a Death Benefit under his or her industry's table of benefits in the Local 282 Pension Trust Fund;

- Pro-Rata Pensioners under the Local 282 Pension Trust Fund, but only if they last worked under the jurisdiction of the Local 282 Pension Trust Fund immediately prior to retirement.

This benefit is provided on a self-funded basis.

Payment of the supplemental life insurance benefit shall be made to the Beneficiary designated in accordance with the Fund's requirements and applicable law. If the Beneficiary predeceased the Participant, or the Participant failed to name a Beneficiary, the benefit shall be paid to the Participant's surviving Spouse or, if there is no surviving Spouse, to the Participant's children, in equal shares or, if there are no children, to the Participant's estate.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS

Accidental death, dismemberment and Loss of sight benefits ("AD&D Benefits") are provided through The Standard. All active Eligible Employees are eligible for accidental death, dismemberment and Loss (as defined below) of sight benefits, but the amount of coverage varies depending on which Industry Plan of Benefits you are covered by.

The benefit for accidental death is in addition to the life insurance.

If your life insurance coverage is continued due to your Total Disability, your AD&D insurance coverage will continue as well.

AD&D Benefits are payable if an active Eligible Employee suffers any of the Losses listed below as a result of an accident, provided that that Loss occurs within 365 days from the date of the accident and accident occurs while the active Eligible Employee is covered by this Fund.

a. Life 100%
b. One hand or one foot 75%
c. Sight of one eye, speech, or hearing in both ears 50%
d. Two or more of the Losses listed in b. and c. above 100%
e. Thumb and index finger of the same hand 25%*
f. Quadriplegia 100%**
g. Hemiplegia 50%**
h. Paraplegia 50%**
i. Uniplegia 25%**
j. Triplegia 75%**
k. Coma ..... 1% per month of the remainder of the AD&D Benefits payable for loss of life after reduction by any AD&D Benefit paid for any other Loss as a result of the same accident. Payments for coma will not exceed a maximum of 60 months.

No more that 100% of the AD&D Benefits will be paid for all Losses resulting from one accident.

*No AD&D Benefit will be paid for Loss of thumb and index finger of the same hand if an AD&D Benefit is payable for the Loss of that entire hand.

**No AD&D Benefit will be paid for loss of function of a hand or foot if an AD&D Benefit is payable for Quadriplegia, Hemiplegia, Triplegia or Paraplegia involving that same hand or foot.

ADDITIONAL AD&D BENEFITS

AIR BAG BENEFIT

The amount of the Air Bag Benefit is 10% of the amount of the AD&D Insurance Benefit if all of the following requirements are met:

1. You die as a result of an automobile accident for which a Seat Belt Benefit, as described below, is payable for Loss of your life.
2. The automobile is equipped with an air bag system that was installed as original equipment by the automobile manufacturer and has received regular maintenance or scheduled replacement as recommended by the automobile or air bag system manufacturer.
3. You are seated in the driver's or passenger's seating position intended to be protected by the air bag system and the air bag system deploys, as evidenced by a police accident report.

CAREER ADJUSTMENT BENEFIT

The Career Adjustment Benefit is payable if the member has a legal spouse on the date of the member's death. The spouse can, within 36 months from the date of the member's death, take education or professional trade courses to increase their earnings.

The maximum benefit is the lesser of 25% of the AD&D benefit payable or $10,000. The maximum annual payout is $5,000 per year.

The Standard will pay a Career Adjustment Benefit to your Spouse if all of the following requirements are met:

1. You are insured for AD&D Benefits.
2. You die as a result of an accident for which an AD&D Benefit is payable for Loss of your life.
3. Your Spouse is, within 36 months after the date of your death, registered and in attendance at an accredited institution of higher education or trades training program for the purpose of obtaining employment or increasing earnings.

If you have no surviving Spouse or your Spouse does not meet the requirement shown in item 3, then no Career Adjustment Benefit will be paid and the Alternative Career Adjustment Benefit will be paid in its place to the Beneficiary you name. The Alternative Career Adjustment Benefit will be a one-time lump sum of $200.

CHILD CARE BENEFIT

The amount of the Child Care Benefit is the expense incurred by your Spouse within 36 months after the date of your death for your children under 13, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D Benefit, whichever is less.

The Standard will pay a Child Care Benefit to your Spouse if all of the following requirements are met:

1. You are insured for the AD&D Benefit.
2. You die as a result of an accident for which an AD&D Benefit is payable for Loss of your life.
3. Your Spouse pays a licensed child care provider who is not a member of your family for child care provided to your child(ren) under age 13 within 36 months of your death.
4. The child care is necessary in order for your Spouse to work or to obtain training for work or to increase earnings.

If you have no surviving Spouse or the requirements shown in items 3 and 4 are not met, then no Child Care Benefit will be paid and the Alternate Child Care Benefit will be paid in its place to the Beneficiary you name. The Alternate Child Care Benefit will be a one- time lump sum payment of $200.

HIGHER EDUCATION BENEFIT

The amount of the Higher Education Benefit is the tuition expenses incurred per child within 4 years after the date of your death at an accredited institution of higher education, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $20,000 or 25% of the AD&D Benefit, whichever is less.

The Standard will pay the Higher Education Benefit to your child if all of the following requirements are met:

1. You are insured for the AD&D Benefit.
2. You die as a result of an accident for which an AD&D Benefit is payable for Loss of your life.
3. Your child is, within 12 months after the date of your death, registered and in full-time attendance at an accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each child who meets the requirements of item 3 above, for a maximum of 4 consecutive years beginning on the date of your death. If you have no surviving children, or your child does not meet the requirements shown in item 3, then no Higher Education Benefit will be paid, and the Alternative Higher Education Benefit will be paid in its place to the Beneficiary you name. The Alternative Higher Education Benefit will be a one-time lump sum payment of $200.

PUBLIC TRANSPORTATION BENEFIT

The amount of the Public Transportation Benefit is 100% of the amount of the AD&D Benefit otherwise payable for Loss of your life.

The Standard will pay a Public Transportation Benefit if all of the following requirements are met:

1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
2. The accident occurs while you are riding as fare-paying passenger on Public Transportation.

Public Transportation means, for purposes of the Public Transportation Benefit, a public passenger conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regular passenger routes with a definite schedule of departures and arrivals.

REPATRIATION BENEFIT

The amount of the Repatriation Benefit is the expenses incurred to transport your body to a mortuary near your primary place of residence, but not to exceed $5,000 or 10% of the AD&D Insurance Benefit, whichever is less.

The Standard will pay a Repatriation Benefit if all of the following requirements are met:

1. An AD&D Insurance Benefit is payable because of your death.
2. You die more than 200 miles from your primary place of residence.
3. Expenses are incurred to transport your body to a mortuary near your primary place of residence.

SEAT BELT BENEFIT

The amount of the Seat Belt Benefit is 10% of the amount of the AD&D Benefit payable for Loss of your life.

The Standard will pay the Seat Belt Benefit if all of the following requirements are met:

1. You die as a result of an automobile accident for which the AD&D Benefit is payable for Loss of your life.
2. You are wearing and properly utilizing a seat belt system at the time of the accident, as evidenced by a police accident report.

Loss, for purposes of AD&D Benefits, means loss of life, hand, foot, sight, speech, hearing in both ears, thumb and index finger of the same hand, coma, and Paraplegia, Hemiplegia, Quadriplegia, Triplegia or Uniplegia which meet all of the following requirements:

1. Is caused solely and directly by an accident.
2. Occurs independently of all other causes.
3. Occurs within 365 days after the accident.
4. With respect to Loss of life, is evidenced by a certified copy of the death certificate.
5. With respect to all other Losses, is certified by a physician in the appropriate specialty as determined by us.

With respect to Loss of life, death will be presumed if you disappear and the disappearance:

1. Is caused solely and directly by an accident that reasonably could have caused Loss of life;
2. Occurs independently of all other causes; and
3. Continues for a period of 365 days after the date of the accident, despite reasonable search efforts.

With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint, whether or not surgically reattached.

With respect to sight, loss means entire, uncorrectable, and irrecoverable loss of sight.

With respect to speech, Loss means entire, uncorrectable, and irrecoverable loss of audible speech.

With respect to hearing, Loss means entire, uncorrectable, and irrecoverable loss of hearing in both ears.

With respect to thumb and index finger of the same hand, Loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.

With respect to coma, Loss means a profound state of mental unconsciousness with no evidence of appropriate responses to stimulation, lasting for at least 7 consecutive days.

With respect to Quadriplegia, Hemiplegia, Uniplegia, Triplegia, and Paraplegia, Loss must be permanent, complete and irreversible.

Quadriplegia means total paralysis of both upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on the same side of the body. Paraplegia means total paralysis of both lower limbs. Uniplegia means the complete and irreversible paralysis of one limb. Triplegia means the complete and irreversible paralysis of three limbs.

AD&D BENEFIT EXCLUSIONS

No AD&D Benefit is payable if the accident or Loss is caused or contributed to by any of the following:

1. War or act of war. "War" for this purpose means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
2. Suicide or other intentionally self-inflicted injury, while sane or insane.
3. Committing or attempting to commit a felony, or actively participating in a riot. Actively participating does not include being at the scene of a riot while performing your official duties.
4. Intoxication or being under the influence of any narcotic, unless used or consumed according to the direction of a physician.
5. Sickness, except as a result of the accident.
6. Pregnancy, except for a complication of pregnancy resulting from the accident.
7. Medical or surgical treatment for any of the above.
8. Boarding, leaving, or being in or any kind of aircraft. However, this exclusion will not apply if the person who suffers the Loss is a fare-paying passenger on a commercial aircraft.

HOW TO CLAIM BENEFITS

For AD&D Benefits, submit an official copy of the death certificate to the Fund Office together with satisfactory proof of the accidental nature of the death, such as a newspaper account of the accident or a medical examiner's report or any additional information that the Fund may require. AD&D benefits are paid to the Beneficiary designated by the Participant in accordance with the Fund's requirements and applicable law.

For dismemberment or Loss of sight benefits, notify the Fund Office in writing of the Loss. Upon receipt of such other satisfactory evidence as may be required, payment for the specified Loss is made to the Participant.

WEEKLY ACCIDENT AND SICKNESS BENEFITS

Your weekly benefit as shown in your Industry Plan of Benefits will be paid to you for Disability resulting from:

- Any non-occupational accident, or
- Any Illness for which you are attended by a Physician and for which you are not entitled to benefits under any Workers' Compensation Law.

For Employees employed by Contributing Employers covered by the New York State Disability Benefits Law (the "NY Disability Law"), the State of New York weekly accident and sickness benefits are payable from the first (1st) calendar day of Disability caused by an accident and from the eighth (8th) calendar day of disability under the NY Disability Law.

For Employees employed by New Jersey Contributing Employers, the State of New Jersey weekly accident and sickness benefits are payable on the eighth (8th) consecutive calendar day of the disability if the disability is due to an illness. To be reimbursed from the first (1st) day the disability began, the person must be on disability for twenty-two (22) or more consecutive calendar days and the disability must be due to an injury, accident or disease. If the person is absent from work for less than twenty-two (22) consecutive calendar days, the first week of disability is not reimbursed by the State of New Jersey.

Benefits are payable for up to 26 weeks in any one period of disability on account of bodily Injury or disease.

Notice of claim for benefits must be filed as set forth below no later than 30 days from the date on which an Illness starts or an accident occurs. Failure to do so may disqualify you for benefits for any period before notice is given.

Successive periods of disability separated by less than two (2) weeks of active work on a full-time basis shall be considered as one period of disability, unless the subsequent disability is due to an Injury or Illness entirely unrelated to the cause of the previous disability and commences after return to active work on a full-time basis.

Employees who have not satisfied the eligibility requirements for Fund benefits will be covered for weekly accident and sickness benefits as prescribed by law.

HOW TO CLAIM BENEFITS

You and your Physician must fill out a claim form (commonly referred to as Form DB-450) that is available from the Fund Office. The Form DB-450 must be filed with the Fund Office **no later than 30 days after the commencement of disability.** Failure to do so may disqualify you for benefits for any period before the notice is given. Therefore, please call the Fund Office **IMMEDIATELY** for a claim form (Form DB-450).

COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health plan. This may lead to a duplication of coverage, *i.e.*, two plans paying benefits for the same dollar of medical charges. In order to prevent duplication of benefit payments, this Fund provides for Coordination of Benefits (COB).

You are required to notify the Fund Office of any other health coverage and to provide any information deemed necessary by the Fund Office to coordinate benefits. In order to obtain all available benefits, you should always file a claim with each plan. The Fund Office may exchange information with other plans in order to coordinate benefits. In addition, the Fund has the right to recover any overpayments made if you or your Dependent fails to report other coverage to the Fund.

Your eligibility for Fund benefits may be discontinued if you fail to provide the Fund Office with information needed to coordinate benefits.

HOW DOES COB WORK?

If you or your Dependents are also covered under another plan, the total amount received from all plans cannot exceed 100% of "Allowable Charges."

DEFINITIONS

"Allowable Charges" for purposes of coordination means any necessary, reasonable and customary item of expense for services, supplies or treatment covered, in whole or in part, by one of the medical or dental plans. The Fund will treat benefits payable by another plan as a benefit paid, whether or not a claim is filed under that plan.

Plan, as used in this section on COB, refers to any of the following plans that provide benefits on an insured or uninsured basis:

a) group blanket or franchise insurance;

b) group Blue Cross, group Blue Shield, group practice or other group prepayment plans;

c) union welfare plans, Employer organization plans, or labor-management trusted plans;

d) governmental programs or coverages required or provided by law. However, "Plan" does not include any government program coverage with which we are not allowed, by law, to coordinate;

e) automobile "No-Fault" contracts, as mandated by state law. However, if you or your Dependent fails to obtain such No-Fault coverage, this Fund will **NOT** pay the benefits required to be provided as basic reimbursement benefits under such law; and

f) group automobile "fault" contract, but only the medical benefits written.

WHICH PLAN PAYS FIRST?

If a Participant or Dependent is entitled to receive benefits under this Fund and under another group health plan, the two plans will coordinate their benefit payments so that the combined payments of both plans will not exceed the Allowable Charges incurred by the patient. One plan (the primary plan) will pay its full benefits. The other plan (the secondary plan) will pay any charges in excess of the primary plan benefits, up to the maximum amount that it would pay if the COB provision were not in force.

1. The following rules below determine which plan's benefits are payable first:
   a) A plan which does not have a COB provision is always primary and pays first.
   b) A plan that covers the individual as an Employee pays first.
   c) If the individual is covered as an Employee under two plans, the plan which has covered the person longer is primary.
   d) A plan which covers the individual as a Dependent under an active Employee's benefits pays before a plan which covers the individual as a retiree.
   e) In the event that both Spouses are active Employees participating in the Fund and are each eligible to receive the same benefits from the Fund, the following procedure shall apply:
      - Both Participants may each file for benefits on a single claim; and
      - Both Participants may each receive reimbursement on that single claim, but in no event shall the total reimbursement on that single claim exceed the actual expense for that single claim OR double payment of the regular schedule allowance, whichever is lower.
      - The Participant who incurred the claim must file the claim first under his or her ID number. After the Participant receives an explanation of benefits, the Spouse may then file the claim for secondary coverage.
2. The rules below determine which plan's benefits are payable first if a Dependent child is covered under two or more plans:
   a) If the parents are not divorced or separated, the plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding year of birth, pays first. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time pays first.
   b) If the individual is a child of separated or divorced parents, the "order of payment" used to determine the primary plan is as follows:
      - the plan of the natural parent with custody of the child pays first.
      - the plan of the stepparent with custody of the child pays before the plan of a natural parent without custody.

- if a court order makes one parent financially responsible for the health care charges of the child, that parent's plan will pay first.

A plan which covers a Dependent as a Dependent under an active Employee's benefits pays before a plan that covers such Dependent as a Dependent of a retiree. This does not apply if either plan does not have a provision regarding laid-off or retired Employees.

If the above rules do not determine which plan's benefits are payable first, the plan that has covered the Participant for the longest time will pay benefits first.

When this Fund pays reduced benefits due to this provision, only the reduced amount will be charged against the payment limits of the Fund.

If another plan pays benefits that should have been reduced because of COB, the Fund may, at its option, pay the amount by which the benefits should have been reduced to the other plan. Amounts so paid will be deemed benefits paid under the Fund, and will reduce the Fund's liability to the extent of such payment.

If the Fund has made payment of any amount that is in excess of that permitted by COB, the Fund has the right to recover such amount from any party that has received such payment.

COB WITH MEDICARE FOR PARTICIPANTS OVER AGE 65 AND STILL WORKING

If you continue to work after age 65, your health benefits provided by the Fund will continue in the same way as before you were 65. Since you are eligible for Medicare benefits at age 65, you may still apply for the coverage described below. However, as long as you are actively employed, unless you make the election described below, Medicare pays benefits only after the Fund pays. If your Spouse is over age 65 and you are actively employed, the Fund will pay your Spouse's benefits before Medicare as long as you are actively employed.

You are eligible for Medicare benefits on the first day of the month that you reach 65. There are two parts to Medicare other than prescription drugs. Part A provides hospitalization benefits, and Part B covers a wide variety of other medical charges. There is no charge for Part A, but there is a monthly charge for Part B. You and your Spouse may want to enroll for Parts A and B as soon as you are eligible. You should apply for Medicare benefits during the three months before your 65th birthday. However, you do not have to enroll in Medicare immediately. As long as you are an active Employee covered by this Fund, you will remain entitled to Fund benefits as long as you satisfy the eligibility rules. Under Federal law you will be allowed to enroll in Medicare (without any penalty) immediately on the date your Fund benefits terminate.

Medicare benefits also include prescription drug coverage under Medicare Part D.

The prescription drug coverage offered by the Fund is, on average for active Fund Participants, expected to pay out as much as The Standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Therefore, you can keep the Fund's coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

SUBROGATION AND RESTITUTION OBLIGATION

ACTS OF THIRD PARTIES

Medical care and disability benefits to or for a person covered under this Fund arising out of an Injury or Illness to or of the covered person that occurs through the act or omission of another person, to the extent that the cost of that care or benefits may be recoverable by, or on behalf of, the covered person(s) in any action of law, judgment, award compromise, insurance, order or settlement, are paid subject to the conditions that the covered person(s), the (their) attorney and any insurance company sign an agreement to repay the Fund in full any sums paid for such medical care or disability benefits from any judgment, award, compromise insurance, order or settlement received. The Fund has the right to recover in full the medical or disability charges paid regardless of whether the covered person actually signs the repayment agreement. It is only necessary that the Accident occurs through the act of a third party and the Fund's right of recovery may be from the third party, any liability or other insurance covering the third-party, the insured's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable. The Fund will not pay fees or costs associated with the claim/lawsuit.

REIMBURSEMENT OBLIGATION/EQUITABLE LIEN BY AGREEMENT

Were you or your Dependent injured in a car accident or other incident in which someone else is liable? If so, that person (or his/her insurance) may be responsible for paying your (or your Dependent's) medical charges. This may also be the case if you or a Dependent slip and fall due to another person's negligence or suffer as a result of medical malpractice.

Waiting for a third party to pay may be difficult. Recovery from a third party may take a long time (you may have to go to court), and your creditors may not wait patiently. Because of this, as a service to you, the Fund will pay you (or your Dependent(s)) benefits, to the extent those benefits would be available but for the actions of the third party, based on the condition described below, including your agreement that you are required to reimburse the Fund in full for any recovery you or your Dependent(s) may receive, no matter how the recovery is characterized, why it is paid, or whether the recovery is specified as being for your medical bills.

Therefore, if you or your Dependent(s) (or anyone on your behalf) receives any benefit from the Fund in connection with an Injury, Illness or other condition for which you and/or your Dependent(s) have or assert any claim, demand, cause of action or right to recover against any third party or parties, then any benefit payments by the Fund shall be made on the condition and with the agreement and understanding that the Fund will be reimbursed by you and/or your Dependent(s) and will be equitably subrogated to you and your Dependent(s) and/or to the extent of the amount or amounts received from such third party or parties by way of lawsuit, judgment, award, settlement, compromise, insurance or order. It does not matter how these amounts are characterized, why they are paid, or whether or not these payments are specified as being for your medical bills. By accepting benefits relating to such Illness or Injury, you and, if applicable, your Dependent(s), agree that the Plan has established a

lien on any recovery you, your Dependent(s), or a legal representative or agent receives. You also agree to assign, upon the Fund's request, any right or cause of action to the Fund.

If you or your Dependent has an Injury or Illness caused by a third party, the Fund will pay benefits for that Injury or Illness, only to the extent those benefits would be otherwise available under the Fund's Summary Plan Description, and subject to the conditions that you or your Dependent (a) not take any action which would prejudice the Fund's ability to recover the amount of benefits paid; (b) cooperate in doing what is necessary to assist the Fund in obtaining any recovery of benefits paid; (c) sign the Fund's Reimbursement, Assignment of Rights and Subrogation Agreement as explained in more detail below, and (d) have any attorney or other agent you retain to seek recovery on your behalf execute the Reimbursement, Assignment of Rights and Subrogation Agreement.

The Fund's reimbursement policy seeks to conserve the assets of the Fund by imposing the medical/disability expense for Injuries, Illnesses or other conditions suffered by Participants and/or their Dependents on the parties responsible for causing the Injury or Illness whether caused by act or omission. The Fund will pay benefits related to such Injury or Illness to the extent benefits are payable under the terms of the Fund, provided that the benefits have not already been paid for by the third party, and only after you or your Dependent (and your attorneys, if applicable) have entered into the Fund's written subrogation and reimbursement agreement. If you choose not to pursue the liability of a third party, the Fund assumes your right of recovery and may pursue your claims against the third party. The Fund also reserves its right to recover the benefit payments from you and has the right to recover the payments whether you or your attorney signs the reimbursement agreement. The Fund's right of recovery may be from you, a third party, the insured's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable. The Fund will not pay the fees or costs associated with any claim or lawsuit you bring against a third party.

In the event you, your Dependent, heir, assign, legal representative or agent, by suit settlement, judgment, award, insurance, order or otherwise, in connection with an Injury or Illness, obtains any recovery from any party or his/her or its insurer (regardless of how this recovery is classified in the settlement or judgment) or any source, the Fund has the right to be reimbursed by you, your Dependent, heirs, assigns, legal representative or agent for the full amount of all benefits paid by the Fund. It does not matter how these amounts are characterized, why they are paid, or whether these payments are specified as being for your medical bills. You and your Dependents and legal representative agree to hold all monies and/or assets received by you, your Dependent, heir, assign, legal representative or agent (or paid on such person's behalf) as the result of such recovery in trust, and not commingled with other assets, on behalf of the Fund to cover all benefit payments by the Fund on your behalf or on behalf of your Dependents, and to disgorge all such monies or assets to the Fund upon demand. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be first used to promptly reimburse the Fund for benefits paid. The Fund has the right of first reimbursement--that is, from the first dollar payable--out of any recovery you or your Dependent obtains,

even if you are not fully compensated for your loss, and even if the recovery is deemed not to be for reimbursement of medical charges. The Fund has a first lien priority of payment without regard to whether you or your Dependent has received compensation for all of your or his or her damages and without regard to whether you or your Dependent has been "made whole".

You are required to notify the Fund Office as soon as possible of any third-party claim you or your Dependent may have for which the Fund has paid or may pay benefits. If you retain an attorney, he or she must notify the Fund within ten days of any demand made or suit filed against a third party. In addition, you are required to notify the Fund immediately of any recovery, whether in or out of court, which you or your Dependent obtains. You agree to forward any recovery received to the Fund Office within ten (10) days of receipt until the Fund has been fully reimbursed. If it is not possible to forward the recovery within ten (10) days, you agree to have any recovery maintained in a separate and identifiable manner and not to distribute any portion of the recovery without the prior, written consent of the Fund.

THE FUND'S RIGHT TO REIMBURSEMENT SHALL NOT BE REDUCED BY THE PAYMENT OF ATTORNEY'S FEES OR COSTS ASSOCIATED WITH THE ACTION UNDER THE "COMMON FUND" DOCTRINE, FEDERAL COMMON LAW "MAKE WHOLE" RULES, EQUITABLE APPORTIONMENT, OR OTHERWISE. THE FUND'S RIGHT OF REIMBURSEMENT FROM ANY FUNDS RECEIVED BY YOU, YOUR DEPENDENT, LEGAL REPRESENTATIVE OR AGENT AS A RESULT OF A JUDGMENT, AWARD SETTLEMENT, OR OTHER ACTION HAS FIRST PRIORITY LIEN OVER ALL OTHER CLAIMS AND RIGHTS, OF ANY OTHER PARTY, INCLUDING, WITHOUT LIMITATION, CLAIMS FOR ATTORNEYS' FEES. ANY REDUCTION OF THE PLAN'S CLAIM IS SUBJECT TO PRIOR WRITTEN APPROVAL BY THE FUND IN ITS SOLE DISCRETION.

The Fund will send you a Reimbursement, Assignment of Rights and Subrogation Agreement. The Fund will not pay benefits for any claims incurred by you or your Dependents resulting from the Injury or Illness until the Fund Office receives a signed Reimbursement, Assignment of Rights and Subrogation Agreement from you and, if you have one, your attorney. The Reimbursement, Assignment of Rights and Subrogation Agreement will require you and your attorney to comply with this Fund's reimbursement policy as set forth in this Summary Plan Description. However, the Fund's right of reimbursement is not dependent upon the execution of such Agreement. If one of your minor Dependents is injured as a result of the act or omission of a third party, the Dependent's parent or legal guardian must sign the Reimbursement, Assignment of Rights and Subrogation Agreement.

The Fund may also periodically require you to provide information as to any claims you assert against any other party as a result of the Injury or Illness. If you refuse to reimburse the Fund or to cooperate with the Fund in obtaining reimbursement, the Fund has the right to recover from you or your attorney or agent any amounts paid and may offset such amounts against any future benefits payable to you or any of your Dependents or deny any subsequent claims. In the event you receive an award or settlement for future medical charges or other benefits provided by the Fund, the Fund will not pay any

benefits until you demonstrate that the full award of future medical benefits has been used to treat the Injury or Illness.

FRAUD

Subject to the terms of the *Affordable Care Act*, the Fund reserves the right to terminate coverage for you and/or your Dependent(s) if you and/or your Dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively, except in certain permitted instances, such as if you or your covered Dependent(s) commit fraud or make an intentional misrepresentation (for example, in enrollment materials, a claim, or appeal for benefits or in response to a question from the Fund Administrator or its delegates). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Fund Office that you or your Dependent is covered under another group health plan and knowingly providing false information to obtain coverage for an ineligible individual are examples of actions that constitute fraud or intentional misrepresentations. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage.

Examples of fraud against the Fund may also include your failure to notify the Fund Office of your divorce, your failure to inform the Fund Office that you have engaged in Disqualifying Employment as defined in the Local 282 Pension Plan, or your acceptance of payment from an Employer for hours of work that should have been reported to the Fund but were not, where you knew or should have known that the Employer would not report the hours. Where a Participant is found to have engaged in fraud, the Fund may suspend or **permanently discontinue coverage for the Participant and his or her Dependents**.

REQUIRED INFORMATION

Every Participant or Beneficiary shall furnish any information or proof required for the administration of the Fund, including, but not limited to, dates of birth and Social Security numbers of the Participant and all Dependents. Failure to furnish such information or proof promptly and in good faith shall be sufficient cause for the denial of benefits.

TERMINATION AND AMENDMENT OF THE FUND

The Board of Trustees intends to continue the benefits described in this SPD indefinitely. The Board of Trustees reserves the right, however, at any time and from time to time to terminate, modify or amend, in whole or in part, any or all of the provisions of the Fund. The Board of Trustees specifically reserves the right, in its sole and absolute discretion, to 1) terminate or amend any Fund benefits, including either the amount or conditions of any benefit, even if such amendment or termination may affect claims already incurred or eligibility already established or retirees; 2) alter or postpone the method of payment of benefits; and 3) amend any other provisions of this Fund. The Fund may be terminated in writing by the Board of Trustees when there is no longer in effect an agreement between any Employers and the Union requiring any Employer contributions to the Fund,

or where the terms of the Fund's Trust Agreement permit. The Fund may also be terminated at any time by the unanimous vote of all of the Trustees of the Fund, with the consent of the Employers and the Union. In the event benefits are materially modified, Participants will be notified prior to the effective date of the modification.

In the event of termination of this Fund, the Board of Trustees shall apply the Fund's assets to pay or provide for the payment of any and all obligations of the Fund, including payment of benefits, and will distribute and apply any remaining surplus in such manner as will, in its opinion, best carry out the purpose of the Fund; provided, however, that no part of the Fund's assets shall be used for purposes other than the exclusive benefits of Participants and their Beneficiaries, administrative charges and other payments in accordance with the provisions of this Fund and Trust Agreement.

MEDICAL BENEFITS

Each new Employee and each Employee who returns to work after an absence of more than one year you must complete an enrollment form designating a Beneficiary for your group life insurance benefits (as described above). The cards can be obtained from the Fund Office. The enrollment form should be sent to the Fund Office as soon as possible.

COMPREHENSIVE HOSPITALIZATION AND MEDICAL-SURGICAL COVERAGE

The Fund provides Network and Out-of-Network benefits for Hospital, medical and surgical coverage on a self-funded basis. If you use a Network provider, you will have reduced out-of-pocket charges. If you use an Out-of-Network provider, you will generally pay a Deductible, a percentage of the Maximum Allowable charges and possibly any charges above the Maximum Allowable amount, depending on what your provider bills. The Fund's reimbursement levels and your out-of-pocket charges vary depending on whether you use Network or Out-of-Network providers, so please read this Section carefully. These benefits are described in detail in the following pages.

NOTE: Some benefits are available ONLY through Network providers.

NETWORK COVERAGE

The Fund has contracted with Anthem Blue Cross and Blue Shield, a national Preferred Provider Organization (PPO), to make its provider network available to Fund Participants. Anthem Blue Cross and Blue Shield has established a network of Physicians, radiologists and laboratories and other providers that have agreed to provide all covered services to you with only a small out-of-pocket cost. Participants and their Dependents have the option of accessing Anthem Blue Cross and Blue Shield's network of primary and specialty care Physicians.

You can choose to visit one of the providers in the Anthem Blue Cross and Blue Shield network when Illness or Injury occurs for lower out-of-pocket costs than you would incur if you visit an Out-of-Network provider. A list of Network providers can be found by calling Anthem Blue Cross and Blue Shield at 1-800-810-BLUE (2583) or by visiting www.bcbs.com.

If you choose a Network provider, your cost is a co-payment that is payable at the time of your office visit. Apart from a co-payment, surgery is covered at 100% if an Anthem Blue Cross and Blue Shield provider is used. **You pay no Deductible or co-insurance.** In addition, there is no co-payment for Network preventive services for which a co-payment is not permitted under the Affordable Care Act. Check with the Fund Office to determine if any particular Network preventive service is covered by the Affordable Care Act.

The choice is yours as to when you use the Network. However, as described in more detail below, **using Network providers is usually significantly less expensive than using Out-of-Network providers.**

Each Participant will receive an Anthem Blue Cross and Blue Shield card. Since the Network Physicians can change at any time, please contact Anthem Blue Cross and Blue Shield for up-to-date information if you want to locate a Network Physician or confirm that your current Physician participates in the Anthem Blue Cross and Blue Shield network.

NETWORK SERVICES

Network services are health care services provided by a Hospital or health care facility or provider that has been selected by Anthem or another Blue Cross and/or Blue Shield plan to provide care to our members. The provider discounts under the Blue Cross and Blue Shield contracts are the primary reason the Fund is able to provide you and your covered Dependents meaningful health coverage at a relatively low cost to you.

When you choose Network care, you get these advantages:

- **Choice** – You can choose any participating provider from a large network of Physicians and Hospitals.
- **Convenience** – Usually, there are no claim forms to file.
- **Cost** – When you use Network medical providers, you only pay a $20 co-payment (or $30 for a specialist visit). Also:
  - If you are having surgery, there is no additional co-payment for the facility or hospital beyond the co-payment for the surgeon.
  - There is no co-payment for designated Network preventive services.

A $7,900 per person / $15,800 per family out-of-pocket limit applies to payments made by you and your Dependents to Network providers, although it is very unlikely that if you use Network providers you will have to pay anything near this amount.

OUT-OF-NETWORK COVERAGE

Unlike the Network providers discussed above, Out-of-Network providers have not signed any contract with Anthem Blue Cross and Blue Shield and have not agreed to accept a discounted reimbursement rate. Instead, Out-of-Network providers can charge you whatever they want to and can bill you for the difference between the amount they bill and what the Fund pays. This is called balance billing, and the differences can be very significant.

In addition, unlike with Network providers, if you use an Out-of-Network provider, the Fund will not begin to pay benefits until the covered individual has satisfied the Deductible of $400 per calendar year. However, there is a

maximum Family Deductible of $800 per calendar year. If two or more family members **each** incur charges for covered services related to Out-of-Network providers ("Covered Charges") that in total exceed $400, the Family Deductible of $800 has been met for that calendar year. Out-of-Network facility (including Out-of Network Hospital) charges are also subject to the same Deductible; and all are payable at 80% of the Maximum Allowable charge.

The Deductible is applied against the incurred Covered Charges of each person **each calendar year,** except that:

- Any Covered Charges incurred during the last 3 months of a calendar year may be used to satisfy all or part of the Deductible for the next succeeding calendar year, to the extent those charges were not used to satisfy the Deductible for the year in which they were incurred, and
- In the event of a single accident resulting in Injuries to two or more covered family members, the Deductible is applied only once per calendar year to all Covered Charges of such individuals as a result of Injuries sustained in the one accident.

Only Covered Charges incurred after the effective date of the individual's coverage may be used to meet the Deductible.

An expense or charge shall be deemed incurred as of the date the service is rendered or the purchase is made from which the expense or charge arises.

Out-of-Pocket Limit: If you pay your Deductible plus $7,900 ($15,800 per family) of Covered Charges during a Plan Year, the Fund will reimburse Covered Charges at 100% of Maximum Allowable charges for the rest of that Plan Year. Remember, however, that the Maximum Allowable charges paid for by the Fund can be significantly less than the amount charged by the provider. Choosing a Network provider will usually result in lower out-of-pocket costs to you.

LIVEHEALTH ONLINE

LiveHealth Online is a service from Anthem Blue Cross that provides access to board-certified physicians 24 hours, 7 days a week, 365 days a year. By registering for the service you will be able to secure a consultation with a doctor that participates in the Anthem Blue Cross network within minutes. Speak to a doctor right from your phone, smartphone, computer or tablet. Get the care you need—including prescriptions.

Make a virtual appointment and speak with a physician in minutes! The Fund has partnered with BlueCross BlueShield to offer LiveHealth Online—telehealth services that connect you to a physician 24 hours a day, seven days a week. It's cheaper and easier than going to your doctor's office. You'll pay just $10 for a virtual visit (instead of $20 for an in-person office visit).

When To Use It

Telehealth services are great for nonemergency conditions, such as:

- Cough and cold
- Pinkeye
- Fever or flu
- Headache or ear pain

- Allergies
- Anxiety and depression

How It Works

Sign up at www.livehealthonline.com or download the mobile app and create an account. View doctor profiles and ratings and select the provider that best fits your needs. Click "Connect" and you'll be connected via two-way video chat with that physician in minutes! The physician can answer your questions, send a report to your primary care physician and even write you a prescription, if needed.

OUT-OF-POCKET COSTS FOR MEDICAL BENEFITS

The following chart shows your specific out-of-pocket charges for certain types of Network and Out-of-Network benefits. See the Definitions section starting on page 10 for explanation of terms in the chart.

	IN-NETWORK	OUT-OF-NETWORK
Emergency Room cost sharing (not resulting in an in-patient admission)	$100 co-payment	Subject to Deductible then Co-Insurance
Primary care Physician services & ancillary benefits cost sharing	$ 20 co-payment	Subject to Deductible then Co-Insurance
Specialist Physician services cost sharing	$30 co-payment	Subject to Deductible then Co-Insurance
Laboratory Tests	*See Below	Subject to Deductible, then Co-Insurance
Out-Of-Network cost sharing	N/A	Subject to Deductible of $400 per person or $800 per family per calendar year followed by balance after allowable payment

**Out-of-Pocket Costs for In-Network Lab Tests:*

For lab tests performed in New York, the copayment for services performed at a **Quest Diagnostics** facility is $20. If the test cannot be performed by Quest Diagnostics, but is performed by another Network provider, the copayment will also be $20. To find a **Quest Diagnostics** lab near you, go to www.questdiagnostics.com or call 888-277-8772. To find out about other Network lab test providers, go to www.bcbs.com or contact the Fund Office at (516) 488-2822.

For lab tests performed in New Jersey, the copayment for services performed at a **LabCorp** facility is $20. If the test cannot be performed by LabCorp, the copayment will also be $20 as long as a different Network provider performs the test. To find a **LabCorp** lab near you, go to www.labcorp.com. To find out about other Network lab test providers, go to www.bcbs.com or contact the Fund Office at (516) 488-2822.

If the lab test can be performed by a Quest Diagnostics lab in New York or a LabCorp lab in New Jersey, but you go to another Network lab in either state,

the copayment for lab tests is $40. To find out about other Network lab test providers, go to www.bcbs.com or contact the Fund Office at (516) 488-2822.

For lab tests performed outside or New York or New Jersey: The co-payment is $20.

There is no co-payment for lab tests that are considered preventive services as long as they are provided by a Network provider (or an Out-of-Network provider if no Network provider offers the preventive test).

To locate a provider in Anthem's operating area, visit www.bcbs.com or call 1-800-810-BLUE (2583)

COVERAGE WHILE TRAVELING

Your coverage is available even if you travel outside your local area through the following programs:

Out-of-Area Services: Anthem Blue Cross Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of the geographic area that Anthem serves (the "Empire Service Area"), the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

BlueCard® Program: When you receive covered services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees: Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside Anthem's Service Area: In addition to any deductible, copayment or co-insurance, you may be responsible for the difference between the amount that the Out-of-Network provider bills and the payment Anthem will make for the covered services. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global Core® Program: If you plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583 or you can call them collect at 804-673-1177.

How claims are paid with Blue Cross Blue Shield Global Core: In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, co-insurance or deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctor services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms, you can get international claim forms in the following ways:

Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or online at www.bcbsglobalcore.com. You will find the address for mailing the claim on the form.

HOSPITAL BENEFITS AT A GLANCE

	YOU PAY	
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK (Subject to Deductible)**
Emergency Room (You must call within 48 hours of admission to certify Hospital stay)	$ 100	20% Co-Insurance
INPATIENT HOSPITAL SERVICES*		
Anesthesia and Oxygen	$0	20% co-Insurance
Cardiac Rehabilitation	$0	20% co-insurance
Chemotherapy & Radiation Therapy	$0	20% co-insurance
Diagnostic X-Ray and Lab Tests	$0	20% co-insurance
Drugs & Dressings	$0	20% co-insurance
General, Special and Critical Nursing Care	$0	20% co-insurance
Intensive Care	$0	20% co-insurance
Kidney Dialysis	$0	20% co-insurance
Semi-Private Room and Board	$0	20% co-insurance
Planned Admission	$0	20% co-insurance
OUTPATIENT HOSPITAL SERVICES		
Diagnostic Procedures X-rays and other imaging	$0	20% co-insurance
MRIs/MRAs and All lab tests	$0	20% co-insurance
Chemotherapy & Radiation Therapy	$0	20% co-insurance
Pre-Surgical Testing (Must be done within 7 days of a planned admission or out-patient service)		
MATERNITY CARE*		
Routine Newborn - Nursery Care (In Hospital)	$0	20% co-insurance
Obstetrical Care (In Hospital)	$0	20% co-insurance
Obstetrical Care (In birthing center)	$0	Not Covered
SAME DAY SERVICES		
Anesthesia and Oxygen	$20	20% co-insurance
Blood Work	$0	20% co-insurance
Same Day (Outpatient) Surgery	$0	20% co-insurance
SKILLED NURSING AND HOSPICE CARE		
Skilled Nursing Facility Up to 120 days per calendar year	$0	Not covered
Hospice Up to 210 days per lifetime	$0	20% co-insurance
HOME HEALTH CARE		
Home Health Care Up to 200 visits combined Network and Out-of-Network per calendar year (a visit equals 4 hours of care)	$0	20% Co-Insurance
Home infusion therapy	$0	Not covered

	YOU PAY	
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK (Subject to Deductible)**
Physical Therapy and Rehabilitation- Up to 60 days of inpatient service combined Network and Out-of-Network per calendar year	$0	20% co-insurance
Up to 30 outpatient visits combined Network and Out-of-Network per calendar year	$20	20% co-insurance
Occupational and Speech Therapy - Up to 30 outpatient facility visits per person combined Network and Out-of-Network per calendar year	$20	20% co-insurance
MENTAL HEALTH CARE		
Inpatient** As Medically Necessary	$0	20% co-insurance
Outpatient	$20	20% co-insurance
ALCOHOL OR SUBSTANCE ABUSE		
Inpatient**	$0	20% co-insurance
Outpatient	$20	20% co-insurance

**All services are subject to pre-certification; refer to page 60 for more information.*

***All non-emergency in-patient services are subject to pre-certification; refer to page 85 for more information.*

EMERGENCY CARE

Emergency care is covered in the Hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy.
- Cause serious problems with your body functions, organs or parts.
- Cause serious disfigurement.
- In the case of behavioral health, place others or oneself in serious jeopardy.

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a Network Hospital or a Hospital in the PPO network of another Blue Cross and/or Blue Shield plan.

Benefits for treatment in a Hospital emergency room are limited to the initial visit for the emergency condition.

You will need to show your Anthem Blue Cross and Blue Shield ID card when you arrive at the emergency room.

If you are admitted to the Hospital, you or your representative **must call** Alicare Medical Management at 1-877-540-6663 within 48 hours or as soon as is reasonably possible. **Benefits may be reduced by 50%, up to $500, for each hospital admission that does not receive authorization.**

If you require emergency behavioral health or substance abuse services, you must call Teamster Center Services at 212-235-5003 or 800-433-4827 within 48 hours, or as soon as reasonably possible, following the emergency.

These Emergency Services Are Not Covered:

Use of the Emergency Room:

- To treat routine ailments.
- Because you have no regular Physician.
- Because it is late at night or on a week-end (and the need for treatment is not sudden and serious).

MATERNITY CARE

In-Network: You are responsible for the co-payment only for your first visit to a Network Physician but not for any subsequent routine visits during your pregnancy. You are responsible for the co-payments on non-routine lab tests performed during your Physician visits. You are not responsible for obstetrics care in Network Hospitals or birthing centers. In addition, routine newborn nursery care is covered 100% if you use a Network provider.

Out-of-Network: You pay the Deductible, co-insurance and any amount above the Maximum Allowable charges for maternity services rendered by Physicians and Hospitals that are Out-of-Network. The Fund does not cover obstetrical care in a birthing center that is Out-of-Network.

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

Whether you are receiving Network or Out-of-Network services, to ensure that you receive maximum benefits, notify the Alicare Medical Management Program at 877-540-6663 in the following situations:

- Upon learning of a high-risk pregnancy
- If mother or newborn remain hospitalized:
  - More than 48 hours following a normal vaginal delivery
  - more than 96 hours following a Cesarean section

Your baby is automatically covered under the Fund for the first 30 days. However, you will need to add the baby's name as a new Dependent. Call the Fund Office within 30 days to add your newborn as a Dependent.

The following are additional covered services and limitations on maternity care coverage provided by the Fund:

- One home care visit if the mother decides to leave the Hospital earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the Hospital or a home health care agency within the relevant timeframe (pre-certification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a Physician.
- Parent education, and assistance and training in breast or bottle feeding, if available.
- Circumcision of newborn males.
- Special care for the baby if the baby stays in the Hospital longer than the mother. Call Alicare Medical Management at 1-877-540-6663 to pre-certify the Hospital stay.
- Semi-private room.

These maternity care services are not covered:

- Days in Hospital that are not Medically Necessary (beyond the 48- hour/96-hour limits).
- Services that are not Medically Necessary.
- Private room.
- Out-of-Network birthing center facilities.
- Private duty nursing.

Use a Network obstetrician/gynecologist to receive the lowest cost maternity care.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, including two prosthetic bras every 12 months; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

HOSPITAL SERVICES

The Fund covers most or all of the cost of your Medically Necessary care when you stay at a Network Hospital for surgery or treatment of Illness or Injury. When you use an Out-of-Network Hospital or facility, you pay the co-insurance, plus any amount above the Maximum Allowable charge.

You are also covered for same-day (outpatient or ambulatory) Hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation, respiratory therapy and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or Hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms
- May require either local or general anesthesia
- Do not require inpatient Hospital admission because it is not appropriate or medically necessary
- Would justify an inpatient Hospital admission in the absence of a same-day surgery program

Remember to call Alicare Medical Management at 877-540-6663 at least two weeks prior to any planned surgery or Hospital admission.

For an emergency admission or surgical procedure, call Alicare Medical Management at 877-540-6663 within 48 hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to $500 for each Hospital admission that is not pre-certified. Benefit reductions will also apply to all care related to the admission services.

The medical necessity and length of any Hospital stay are subject to Alicare Medical Management guidelines. If Alicare Medical Management determines that the admission is not Medically Necessary, no benefits will be paid. See the Health Management section for additional information.

When you use a Network Hospital, you will not need to file a claim in most cases. When you use an Out-of-Network Hospital, you may need to file a claim with Anthem.

OUT-PATIENT HOSPITAL CARE

The following are additional covered services and limitations when performed in the outpatient (same-day) care department of a Hospital:

- Diagnostic procedures and lab tests
- Blood and blood derivatives. For emergency care, same-day surgery, or Medically Necessary conditions, such as treatment for hemophilia, this benefit is available on an outpatient basis only
- MRIs/MRAs when pre-approved by Alicare Medical Management (1-877-540-6663)
- Cervical cancer screenings. This includes a pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear

- Mammogram: Routine Mammograms will be reimbursed at 100% subject to the ACA preventive care guidelines with no Deductible or co-payment. The Fund covers one routine mammogram per calendar year. Diagnostic mammograms will be covered subject to the ACA limitations in the previous sentence.
- Same-day and Hospital outpatient surgical facilities
- Chemotherapy and radiation therapy, including medications that are part of outpatient Hospital treatment if they are prescribed by the Hospital and filled by the Hospital pharmacy
- Physical, Occupational, Speech and Vision Therapy, up to 30 visits per calendar year, when pre-approved by Alicare Medical Management
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for ESRD dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a Physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)
  - In a Hospital-based facility
  - In a free-standing facility

Exclusions

- Same-day surgery not pre-certified as Medically Necessary by Alicare Medical Management
- Routine medical care including but not limited to:
  - Inoculation or vaccination (except as covered under the medical portion of the benefits)
  - Drug administration or injection, excluding chemotherapy

INPATIENT HOSPITAL CARE

Covered Services

- Semi-private Room and Board when:
  - The patient is under the care of a Physician, and
  - The Hospital stay is Medically Necessary
- Coverage is for unlimited days, subject to Alicare Medical Management's review, unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the Hospital
- Cardiac care unit
- Services of a licensed Physician or surgeon employed by the Hospital (if their services are included in Hospital charges)
- Use of cardiographic equipment

- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Inpatient physical, occupational, speech and vision therapy including facilities
- Chemotherapy and radiation

Exclusions

- Private-duty nursing, even if Medically Necessary
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the Hospital's average charge for a semi-private room. The additional cost cannot be applied to your co-insurance.
- Days in Hospital that are not Medically Necessary
- Services that are not Medically Necessary
- Diagnostic inpatient stays, unless connected with specific symptoms that, if not treated on an inpatient basis, could result in serious bodily harm or risk to life
- Services performed in the following:
  - Nursing or convalescent homes, except as provided below
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except for physical therapy)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps
- Any part of a Hospital stay that is primarily for Custodial Care
- Elective cosmetic surgery or any related complications
- Hospital services received in clinic settings that do not meet the definition of a Hospital, as defined on page 12, or other covered facility.

HOSPITAL CLAIMS

If You Need To File A Hospital Claim

Anthem's Hospital Plan makes health care easy by paying providers directly when you stay in a Network Hospital. Therefore, when you receive care from providers or facilities in the Anthem or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services from an Out-of-Network provider, or if you have a medical emergency outside the Empire Service Area. To obtain a claim form, call customer service.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
Hospital	Provider files claim directly with Anthem or local Blue Cross/Blue Shield plan	Provider files claim with Anthem or local Blue Cross/ Blue Shield plan in most cases*

**At some out-of-area and Out-of-Network Hospitals, you may have to pay the Hospital's bill and submit the claim yourself. If this happens, include an original itemized Hospital bill with your claim form.*

Send completed forms to and itemized Hospital bills to:

For New York Residents only

Anthem Blue Cross and Blue Shield
BlueCard Program
P.O. Box 3877
Church Street Station
New York, NY 10008-3877

For residents of all other States, please forward your claim to that State's local Blue Cross and Blue Shield carrier.

Tips for Filing a Claim

- Contact the Fund Office to have a claim form mailed to you.
- Complete all of the information requested on the claim form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Anthem is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill and claim form.
- Keep a copy of your claim form and all attachments for your records.

ORGAN TISSUE TRANSPLANTS

The Fund will provide coverage under your regular Hospital, or medical/surgical benefits for certain services associated with specific organ and tissue transplants in accordance with the limitations described on below. These benefits are only available when the Participant or Dependent is the patient receiving the organ tissue transplant.

WHAT WILL BE COVERED?

Benefits are payable through the Fund for covered organ and tissue transplant services up to the maximum levels shown below in the Maximum Amount of Benefits for Organ and Tissue Transplants in this Section. These charges must be incurred during a transplant benefit period that begins while you or your Dependents are covered under the Fund.

In order to qualify for these benefits, you must contact Alicare Medical Management at 1-877-540-6663.

COVERED SERVICES AND PERIODS

1. Covered Organ and Tissue Transplant Procedures: The following organ and tissue transplants or combinations are covered:
    - Bone marrow
    - Kidney
    - Cornea
    - Heart
    - Heart and Lung
    - Liver
    - Lung; and
    - Pancreas
2. Covered Organ and Tissue Transplant Services: The following services are covered for those organ and tissue transplants that have been described above, in accordance with the Maximum Amount of Benefits for Organ and Tissue Transplants found later in this Section:
    - Organ and tissue procurement, which includes the removal, preservation of and transportation of the donated part.
    - Reasonable and necessary transportation costs with one companion to and from the site of the transplant. If the person to receive the transplant is a minor, or mentally impaired, reasonable and necessary transportation costs for two companions will be covered.
    - Reasonable and necessary food and lodging costs incurred by you or your Dependent and your travel companion(s) will be reimbursed according to the Schedule of Benefits.
    - Hospital Room and Board.
    - Physician services including diagnosis, treatment and surgery.

- Private duty nursing if provided on an outpatient basis by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
- Durable medical equipment.
- Diagnostic and radiological services.
- Approved immunosuppressant drugs.
- Rehabilitative therapies for a condition directly related to the transplant.
- Surgical supplies and dressings, anesthesia and its administration, and operating room fees.

3. Covered Transplant Benefit Period: Covered charges will be paid for the benefit period, which begins five days before the date of the organ or tissue transplant and ends eighteen months afterwards.
4. Qualified Transplant Center: Organ and tissue transplants must be performed at those major medical centers approved to perform such transplants by the Federal government or by the appropriate State Agency in the State where the center is located.

MAXIMUM AMOUNT OF BENEFITS FOR ORGAN AND TISSUE TRANSPLANTS

The following Maximum Amounts apply to covered organ and tissue transplants under this program per transplant benefit period:

1. Organ and Tissue Procurement: not to exceed $10,000.
2. Transportation, Lodging and Meals: itemized receipts must be submitted for reasonable and necessary charges. Total combined costs for the patient and all companions are not to exceed $10,000 per benefit period or $250 per day.
3. Private Duty Nursing: not to exceed $5,000.
4. Other Charges: will be covered up to 100% of the Maximum Allowable charges.

If you or your Dependent requires two or more transplants during your lifetime, these will be treated as follows:

- If due to unrelated causes, they will be treated as falling under separate benefit periods;
- If due to related causes, they will be treated as falling under separate benefit periods if:
  - you or your Dependent returns to active work in between the two periods for at least one week; or
  - in the case of a non-working Dependent, the periods are separated by at least three months;
- If they are due to related causes, but are not separated in time as shown above, they will be treated as falling under one benefit period.

EXTENDED ORGAN AND TISSUE TRANSPLANT BENEFIT

If you or one of your Dependents is in a transplant benefit period when coverage under this Fund is terminated and maximum organ and tissue transplant benefits have not been exhausted, coverage for organ and transplant benefits shall continue in accordance with the rules described until the end of the time allowable for a transplant benefit period.

DONOR SEARCH IS NOT A COVERED BENEFIT.

SKILLED NURSING AND HOSPICE CARE

You receive coverage through the Fund for inpatient care in a skilled nursing or hospice facility. Benefits are available for services provided in a Network skilled nursing facility only. Both Network and Out-of-Network hospice are covered, but there is no out-of-pocket cost at a Network facility.

Please call 1-877-540-6663 to pre-certify skilled nursing and hospice care with Alicare Medical Management. If you fail to pre-certify, your claim will be denied.

Skilled Nursing Care

You are covered for inpatient care in a Network skilled nursing facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in Your Hospital Benefits At A Glance. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The Physician provides:
  - A referral and written treatment plan
  - A projected length of stay
  - An explanation of the services the patient needs, and
  - The intended benefits of care
- Care is under the direct supervision of a Physician, registered nurse (RN), physical therapist, or other health care professional.

Exclusions From Skilled Nursing Care Coverage

- Skilled nursing facility care that primarily:
  - Gives assistance with daily living activities
  - Is for rest or for the aged
- Convalescent care
- Sanitarium-type care
- Rest cures

Hospice Care

The Fund covers up to 210 days of hospice care once per lifetime. Hospices provide medical and supportive care to patients who have been certified by their Physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a Hospital, or at home. Both Network and Out-of-Network Hospice care is available.

The following are additional covered services and limitations related to hospice care:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical care given by the hospice Physician
- Drugs and medications prescribed by the patient's Physician that are not Experimental and are approved for use by the most recent Physicians' Desk Reference
- Physical, occupational, speech and respiratory therapy when required for control of symptoms
- Laboratory tests, X-rays, chemotherapy and radiation therapy
- Social and counseling services for Dependents, including bereavement counseling visits until one year after death
- Transportation between home and Hospital or hospice when Medically Necessary
- Medical supplies and rental of durable medical equipment
- Up to 14 hours of respite care in any week

HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a Hospital or a skilled nursing facility. You receive full coverage when you use a Network provider. For Out-of-Network home health care, you pay a co-insurance. Out-of-Network agencies must be certified by New York State or have comparable certification from another state.

Remember, in order to receive maximum benefits, you need to pre-certify home health care through Alicare Medical Management. If you use a Network home health care agency, the agency is responsible for calling Alicare Medical Management. If you use a home health care agency that is Out-of-Network, *you* need to call Alicare Medical Management at 877-540-6663. (The agency can call for you, however, you need to ensure that it does in fact make the call.)

Home infusion therapy, a service sometimes provided during home health care visits, is only available from Network providers. If you use Network home infusion supplier, the supplier must call Alicare Medical Management for pre-certification. While a BlueCard PPO supplier can call to pre-certify your treatment, you need to ensure that they call.

A Network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact the Fund Office.

The following are additional covered services and limitations regarding home health care:

- Up to 200 pre-certified home health care visits per year, combined Network and Out-of-Network. Your Physician must certify home health care as Medically Necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Skilled nursing
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a Physician
  - Laboratory tests

Exclusions:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Outpatient physical, occupational and speech therapy services, as well as inpatient physical therapy, are available Network and Out-of-Network.

Please call Alicare Medical Management at 877-540-6663 to pre-certify all physical, occupational and speech therapy. This will ensure that you receive maximum benefits. If you fail to pre-certify, your claim will be denied.

In order to receive coverage for these types of therapy services on an inpatient or outpatient basis, up to the Fund maximums, the therapies must be:

- Prescribed by a Physician
- Designed to improve or restore physical functioning within a reasonable period of time, and
- Approved by Alicare Medical Management

In addition:

- Outpatient care must be given in an outpatient facility
- Inpatient therapy must be short-term
- Occupational or speech therapy, or any combination of these on an outpatient basis, will be covered, up to the Fund maximums, if:
  - Prescribed by a Physician or in conjunction with a Physician's services;
  - Given by skilled medical personnel in an outpatient facility; and
  - Performed by a licensed speech/language pathologist or audiologist.

Exclusions:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities
- Tests, evaluations or diagnoses received within the 12 months prior to the Physician's referral or order for occupational or speech therapy

LIMITS

Chiropractic Services

There is a 30-visit limit per calendar year for chiropractic services per covered person. There is a $20 co-payment per visit for Network services. Out-of-Network services are subject to the annual Deductible and co-insurance, and payment to the Out-of-Network provider is limited to Maximum Allowable charges.

Pain-Management Services

There is a 6-visit limit per calendar year for pain management services per covered person. There is a $30 co-payment per visit for Network services. Out-of-Network services are subject to the annual Deductible and co-insurance, and payment to the Out-of-Network provider is limited to Maximum Allowable charges.

CHARGES MUST BE NECESSARY AND REASONABLE

Charges for the care of a covered person as the result of an Injury, pregnancy, or Illness must be Medically Necessary and Reasonable, as determined by the Trustees, to be considered for payment. Any portion of a charge that is determined to not be Medically Necessary and Reasonable will not be considered for reimbursement. Any services not prescribed by a Physician or Dentist as Medically Necessary for the covered person will not be considered for payment.

CHARGES MUST BE INCURRED WHILE COVERED

The Fund will not pay any charges incurred by a person while such person is not covered under the Fund.

SURGERY

If you use a Network surgeon, your surgical procedures(s) will be paid in accordance with the provider's contract with Anthem Blue Cross and Blue Shield, less your co-payment. If you use an Out-of-Network surgeon, charges will be paid at 80% of the Maximum Allowable charge, subject to the annual Deductible.

ASSISTANT SURGEON

Network Assistant Surgeons will be paid in accordance with their contract with Anthem Blue Cross and Blue Shield, less your co-payment. Assistant Surgeons are paid by calculating 20% of the Maximum Allowable charge for the procedures and paying 80% of that figure after the Deductible. Thus, for example, if the Maximum Allowable charge for a procedure is $100, the Assistant Surgeon is paid

$16, i.e., 20% of $100 is $20, and 80% of $20 is $16. Physician's Assistants who act as Assistant Surgeons when required will be covered as Assistant Surgeons, except that the Fund will pay by calculating 10% of the Maximum Allowable charge for the procedures and paying 80% of that figure after the Deductible. For example, if the Maximum Allowable charge for a procedure is $100, the Physician's Assistant is paid $8, i.e., 10% of $100 is $10, and 80% of $10 is $8. Certified Registered Nurse Anesthetists are not covered as Assistant Surgeons.

CO-SURGEON

If two surgeons work as co-surgeons during the same operative session, they will each be paid at 50% of the Maximum Allowable charge for the procedures performed as co-surgeons. Thus, for example, if the Allowable Charge for a procedure is $100, each co-surgeon is paid $50. If they are Network surgeons, they will be paid at 50% of their contract rate with Anthem Blue Cross and Blue Shield, subject to your co-payment.

The Fund will pay for only one assistant surgeon or it will pay for co-surgeons, but it will not pay for both an assistant surgeon and co-surgeons in the same operative session.

WELL CARE

Well care is covered only once every 12 months, and only if you use a Network Physician. This benefit includes all vaccines and immunizations.

OUTPATIENT MENTAL/NERVOUS

You and your Dependents are entitled to Medically Necessary and appropriate psychological or psychiatric care. The provider must be a psychiatrist, licensed psychologist, or licensed social worker**.** See pages 85-86 for more details.

WHAT ARE COVERED MEDICAL CHARGES?

Covered Medical Charges are charges actually incurred, up to the Maximum Allowable charge, for the services and supplies listed below upon the recommendation of the attending Physician and required for treatment of you or your Dependents.

Covered Medical Charges Include, in addition to those already listed earlier in this SPD:*

- ABA Therapy as deemed Medically Necessary by Alicare Medical Management, and provided that the services are not part of an educational program.
- Acupuncture when performed by a Physician.
- Anesthetics and their administration.
- Breast reduction surgery, subject to **prior** approval by Alicare Medical Management.
- Cardiac rehabilitation is covered up to a maximum of 36 sessions per cardiac episode, when accompanied by a Physician's letter stating that it is Medically Necessary and pre-certified through Alicare Medical Management.

- Charges related to smoking cessation, other than charges for any items listed under "Exclusions" anywhere in this SPD.
- C-Pap machine (rental up to the purchase price, then maintenance and supplies covered twice per calendar year).
- Dentist's or Oral Surgeon's Services for treatment of fractures and dislocations of the jaw and certain cutting procedures in the oral cavity. Dental care or treatment due to an Injury to sound natural teeth within twelve months of the accident.
- Diabetic supplies.
- Emergency transportation service by professional ambulance to and from the Hospital but limited to the first trip to and from a Hospital for any one Injury, Illness or pregnancy.
- EMG's when accompanied by a letter from a Physician demonstrating that the service is Medically Necessary.
- Gastric bypass or gastric banding procedures will be covered only with **prior** approval by Alicare Medical Management.
- Genetic or BRCA testing if **prior** approval is granted by Alicare Medical Management.
- Medical supplies, including:
  a) Braces and orthotics (once every two years).
  b) Surgical supplies, including bandages, dressing and appliances to replace physical organs or parts or to aid in their functions when impaired, but limited to the initial charge for the first such appliance.
  c) Oxygen and rental of equipment for its administration.
  d) Rental of a wheel chair or Hospital-type bed (up to purchase price).
- Nursing Care by a trained nurse who is not a member of your immediate family or does not reside in your home, when the attending Physician certifies in writing that nursing care is Medically Necessary and subject to **prior** approval by Alicare Medical Management.
- One visit per lifetime to a diabetic counselor or nutritional therapist for consultation, except that there is no limit on the number of visits to nutritional therapists for Medically Necessary treatment for eating disorders. However, all nutritional therapy, whether for eating disorders or for medical reasons such as diabetes, is subject to a $3,000 lifetime cap.
- Physician's Services for a surgical procedure and other medical care and treatment.
- Purchase of blood pressure monitor, when accompanied by a Physician's letter stating that it is Medically Necessary.
- Rental of respiratory paralysis equipment (up to purchase price).
- Services of a midwife instead of a Physician for the delivery of your baby will be covered to the same extent as if delivery were done by a Physician. The Fund will not, however, pay a claim for both a Physician and a midwife.

- Stem-cell harvesting, enrollment, and storage. No benefit is payable for administration fees.
- Tens unit with 8 electrodes per month when prescribed by a Physician with a letter stating that it is Medically Necessary.
- Treatment of medical conditions related to the eye with appropriate medical diagnoses when performed by ophthalmologists.
- Treatment of varicose veins, with a lifetime maximum of $5,000 per leg, per lifetime, subject to prior approval by Alicare Medical Management.
- Treatment provided by a physician assistant or nurse practitioner for Office Visit services only.
- Tubal ligation
- Vasectomies, limited to one per lifetime. Reversal of a vasectomy is not covered.
- Wigs for post-cancer treatment only, up to a maximum of $750. Replacement wigs allowed every 5 years.
- Prosthetic Bra – limited to 2 every 12 months
- X-ray and laboratory examinations made for diagnostic or treatment purposes.

***Your Physician must certify in writing that all medical supplies over $100 are Medically Necessary.**

WHAT MEDICAL CHARGES ARE NOT COVERED?

No payment shall be made for charges incurred as a result of any of the following:

- Abortions, except if Medically Necessary for the health of the patient.
- Ambulette services.
- Any charges associated with the repair or damage caused by cosmetic surgery, including breast implants and any other elective surgeries deemed not Medically Necessary.
- Charges for Custodial Care.
- Charges from the same provider for multiple office or Hospital visits on the same date.
- Charges incurred as the result of the commission of a crime.
- Charges that you would not be required to pay if there were no insurance or health plan coverage.
- Confinement in a Hospital operated by the United States of America or any agency thereof.
- Confinement in a place which is primarily a school, a place of rest, a place for the aged, or a nursing home.
- Cosmetic Surgery.
- Extracorporeal therapy.

- Eyeglasses, hearing aids or dental prosthetic appliances, except as provided through the Optical, Hearing Loss, or Dental Programs.
- Home Health Aides.
- Hospital, medical or surgical procedures or treatments which are considered Experimental.
- Injuries or Illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law, including No-Fault Automobile Insurance.
- Laser Keratotomy.
- Optometric Vision Therapy, except as provided through the Optical Benefits program (see pages 75-76)
- Personal convenience items.
- Physical performance testing.
- Prescription drugs or medicines other than as provided through the prescription drug benefits described on pages 81 through 84. Prescription drugs or medicines are provided through this Plan's prescription drug benefit program only.
- Reversal of Vasectomies.
- Routine eye examinations, except as provided through the Optical Benefits program (see pages 75-76).
- Services of a Dentist, except as provided on pages 77-81.
- Services or supplies which are not Medically Necessary.
- Services provided by a family member.
- Sex change operations or treatments including hormone therapy, other than treatment for mental health conditions.
- Surgical Trays.
- Treatment for infertility.
- Treatment of Temporomandibular Joint (TMJ) syndrome.
- Vitamins.
- Weight Loss Programs and Supplements.
- Well Care (including Immunizations) provided by Out-of-Network providers.

PRE-CERTIFICATION THROUGH ALICARE MEDICAL MANAGEMENT

The medical management program is administered by Alicare Medical Management. Alicare provides pre-certification for certain covered services and includes a 24-hour Nurse Helpline for answers to any questions regarding your health. To pre-certify service or access the 24-hour Nurse Helpline please call the toll-free number 1-877-540-6663 and advise the telephone representative that you are a Participant in the Fund. Please remember that it is your responsibility to get pre-certification for you or your Dependent ***before*** receiving these services, or within 48 hours of an emergency admission. There is no cost to you and the call is confidential.

The following services require pre-certification through Alicare Medical Management:

- Ambulatory (outpatient) Surgery
- Cardiac Catheterization
- Cardiac Rehabilitation
- Durable Medical Equipment in excess of $1,000
- Genetic or BRCA testing
- Home Health Care
- Home infusion therapy
- Hospice
- Hospital inpatient admissions, including maternity
- MRI/MRA
- Physical, Speech, and Occupational Therapies
- Skilled Nursing Facilities
- Treatment of varicose veins

WHEN SHOULD YOU CALL?

- For **elective (planned) hospital confinement,** please call at least fourteen (14) days prior to admission. If you are going to be admitted sooner than fourteen days, call the toll free number as soon as you know what day you will be admitted to the Hospital.
- For **emergency hospital confinement,** please call within 48 hours after your admission. You may have a Spouse, relative, friend, or even your Physician or the Hospital make the call for you.
- For **maternity cases,** please call within the first three (3) months, or as soon as possible after confirmation of pregnancy, and again when you are hospitalized.
- For **inpatient or outpatient surgery,** please call at least fourteen (14) days prior to elective surgery when recommended by your doctor.

FAILURE TO PRE-CERTIFY WILL RESULT IN A REDUCTION OF BENEFITS OF UP TO $500.00.

CASE MANAGEMENT

If You Need Additional Support for Serious Illness

Alicare Medical Management's case management staff can provide assistance and support when you or a Dependent faces a chronic or catastrophic Illness or Injury. Staff nurses can help you and your family:

- Find appropriate, cost-effective health care options
- Reduce medical costs
- Assure quality medical care

A Case Manager serves as a single source for patient, provider, and the Fund – assuring that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer
- Stroke
- AIDS
- Chronic Illness
- Hemophilia
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case by case basis. In some situations, Alicare Medical Management's staff will initiate a review of a patient's health status and the attending Physician's plan of care. They may determine that a level of benefits not necessarily provided by Anthem's Hospital Plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an Illness or surgery, contact Alicare Medical Management at 1-877-540-6663.

HOW TO CLAIM MEDICAL/SURGICAL BENEFITS

Network providers are required to file their own claims. Out-of-Network providers may still submit their claims to the local Blue Cross and Blue Shield. In the event an Out-of-Network provider will not submit a claim on your behalf, please contact the Fund Office for a claim form, which must be included with your submission. Network claims must be filed within 6 months of the date of service. Out-of-Network claims must be submitted within 12 months after the date the medical services stated in the claim were performed. Failure to follow these steps may disqualify you for coverage for any such claim.

IMPORTANT:
YOU MUST ANSWER ALL HIGHLIGHTED QUESTIONS ON THE CLAIM FORM, INCLUDING SPOUSE'S EMPLOYMENT AND OTHER INSURANCE INFORMATION, AS WELL AS ACCIDENT DETAILS, IF APPLICABLE. FAILURE TO DO SO MAY RESULT IN DELAYED PROCESSING OR DENIAL OF YOUR CLAIM.

OPTICAL BENEFITS

Eligible Employees and their Dependents can obtain Optical Benefits through one of the Fund's Optical Providers - **General Vision Services, Inc**. (GVS), **Vision Screening Inc, or CPS Optical**. If you choose not to, or are unable to, utilize any of the three providers, you can be reimbursed for an Out-of-Network optical provider up to $150. These options are explained below.

Note that all services must be obtained at one time from one provider. The Optical Benefits may not be split between providers.

OPTICAL BENEFITS PROVIDED THROUGH GENERAL VISION SERVICES, VISION SCREENING, AND CPS OPTICAL

You and your Dependents are entitled to receive the following benefits once every calendar year based on the Anniversary Date of your receipt of the benefit.

Exam

A comprehensive eye examination, which includes tonometry (glaucoma testing);

AND

Glasses

- A selection of single vision, conventional bifocals, blended bifocals, trifocals, standard progressive, cataract, polycarbonate (SV for children 16 years or younger), safety and oversize lenses;
- A selection of various frames;
- Cosmetic tinting, prescription sunglasses, ultra-violet coating and scratch resistant coating.

OR

Contact Lenses

- A 12-month supply (8 boxes, 48 Lenses) of Basic Disposable Contact Lenses.

More detailed information on the specific benefits available through GVS, Vision Screening, and CPS Optical, are contained in brochures available from each provider and can also be requested from the Fund Office.

HOW TO OBTAIN YOUR OPTICAL BENEFITS

Locations for participating offices can be found at Local 282's website, www.teamsterslocal282.com or by visiting any of the websites listed below:

Optical Provider	Website	Telephone
GVS	www.generalvision.com	1-800-VISION-1
Vision Screening	www.visionscreeninginc.com	1-800-652-0063
CPS Optical	www.cpsoptical.com	1-888-675-3137

OUT-OF-NETWORK BENEFITS

The Fund will pay up to $150 for the cost of an eye examination and/or prescription eyeglasses for you and each of your Dependents once every 12 months based upon your Anniversary Date. You can choose any eye doctor, as long as the doctor is a qualified registered optometrist or ophthalmologist.

To obtain benefits through the Optical Plan:

1. Contact GVS to obtain a Refund Claim Form.
2. Have the Claim Form fully completed by a qualified registered optometrist or ophthalmologist.
3. Return the Claim Form to GVS with a paid receipt and itemized bill within one year from the date of service.

HEARING BENEFITS

Hearing benefits are available for eligible **Participants only**. No coverage is provided for any Spouse or other Dependent. The Hearing benefits are administered through General Hearing Services (GHS) Silver Plan Program.

There is no Out-of-Network hearing benefit. You must use GHS in order to receive the benefit.

The Silver Plan Program provides a hearing aid benefit of up to $1,000.00 for one hearing aid per ear, once every three years. For hearing instruments NOT included in the Silver Plan Program, you pay the retail price minus the benefit plan allowance ($1,000.00) minus any additional manufacturer's suggested retail price discounts available at the time of the purchase. Under the Silver Plan Program you will receive:

- Free hearing screening
- Two of the following hearing instruments (one per ear) once every three years subject to a $150 co-pay per hearing aid:
  - Advanced Behind-the-Ear
  - Advanced Receive-in-the-Ear
  - Advanced In-the-Ear
  - Advanced Completely-in-the-Canal
- 3-year warranty for repair and 1 year of free batteries

Please note that the benefit can be applied toward any upgraded Digital Programmable Hearing Aid Instrument.

If you have any questions or wish to access your benefits under the Silver Plan Program, please call GHS toll free at 1-888-899-1447. Please identify yourself as a member in the Local 282 Welfare Trust Fund.

DENTAL PROGRAM

Administered by: **Sele-Dent, Inc.**
One Huntington Quadrangle, Suite 1S03 • Melville, NY 11747
Tel: (800) 520-3368

The Fund provides dental benefits through Sele-Dent, Inc. for covered dental services.

The following is a brief description of the dental benefits available from the Fund.

SCHEDULE OF BENEFITS

The following benefits will be paid for covered dental services and supplies furnished to you and your Dependents, by a Dentist, while you and your Dependents are covered under the Fund. All benefits other than orthodontic benefits are subject to a maximum dental benefit payable of $2,250 per covered individual age 19 or older per calendar year. Orthodontic benefits are subject to a separate limitation. The lifetime maximum orthodontic benefit payable is $2,250 per covered individual, regardless of age. No charges will be paid after

these maximums are met. Covered dental charges will be reimbursed as set forth below:

IN-NETWORK BENEFITS

If you are treated by a provider that participates in the Sele-Dent, Inc. network, the following benefits will apply:

Preventive & Diagnostic:	100% payable
Basic & Restorative:	100% payable
Major Services:	100% payable

THERE IS NO DEDUCTIBLE FOR IN-NETWORK SERVICES.

OUT-OF-NETWORK BENEFITS

If you are treated by a provider that does not participate in the Sele-Dent network, the following benefits will apply:

Preventive & Diagnostic:	100% of Maximum Allowable charges
Basic & Restorative:	80% of Maximum Allowable charges
Major Services:	50% of Maximum Allowable charges

Major Services are defined as Bridges, Crowns and Dentures only.

THERE IS A $50.00 INDIVIDUAL AND $150.00 FAMILY MAXIMUM DEDUCTIBLE PER CALENDAR YEAR FOR BASIC, RESTORATIVE AND MAJOR SERVICES WHEN VISITING AN OUT-OF-NETWORK PROVIDER.

LIMITATIONS

- Two oral exams in one twelve-month period.
- Two prophylaxes (cleanings) in one twelve-month period.
- One panorex X-ray every two years.
- One full mouth series every two years.
- Covered children may receive covered sealants up to the age of 16.
- Covered children are permitted one fluoride treatment each year until the age of 16.

NOTE: For Participants of Plan D and their Dependents, a reduced schedule of benefits applies. For additional information about these limitations, please call Sele-Dent.

DESCRIPTION OF DENTAL EXPENSE BENEFITS

Important Benefit Information

An expense will be considered to be incurred on the date the service is performed or the supply is furnished, not on the date the bill is received.

If during the course of treatment a patient is transferred from one Dentist to another, or if more than one Dentist renders service on one dental procedure, the benefits will be determined as though one Dentist had furnished all treatment. However, each Dentist rendering treatment is required to submit his/her own claim form.

ORTHODONTIA

IN AND OUT-OF-NETWORK BENEFIT

Diagnostic Casting (study models):	$200.00
Initial Appliance:	$512.50
Passive or Active Monthly Treatment:	$ 57.75

The above Maximum Allowable charges are payable at 100%.

PRE-CERTIFICATION OF ORTHODONTIA BENEFITS

Pre-certification of benefits permits the review of the proposed treatment, in advance, and allows for resolution of any questions before, rather than after, the work has been done. Additionally, both you and the Orthodontist will know, in advance, what is covered and what the estimated reimbursement will be.

YOU MUST OBTAIN A PRE-TREATMENT REVIEW FROM SELE-DENT BEFORE YOU START ORTHODONTIC TREATMENT. IN ORDER TO OBTAIN A PRE-TREATMENT REVIEW, YOUR DENTIST MUST SUBMIT FULL X-RAYS.

PROSTHETIC APPLIANCES, FIXED BRIDGEWORK AND CROWNS

Benefits will not be provided for the replacement of any dentures, fixed bridgework or crowns, if benefits for these appliances had been provided under the Fund within the last five (5) years. However, if five (5) years have elapsed from the date of installation of any such appliances, benefits will be payable pursuant to the Schedule of Dental Procedures.

This five (5) year limitation also applies to the replacement of a prosthetic appliance by fixed bridgework. However, if an immediate (temporary) denture, for which the charge was less than the allowance in the Schedule, is replaced by a permanent denture within a five (5) year period, the excess of the Schedule allowance over the charge for the immediate (temporary) denture is available as reimbursement towards the charge for the permanent denture.

Fees, for removable partial maxillary or mandibular replacement with a partial denture will not be covered unless three or more permanent teeth are missing from either the right or left quadrants of the maxillae or mandible (excluding third molars).

The Fund will determine an appropriate payment for any dental procedure not covered under the Schedule and not otherwise excluded under the Fund. In no event will the payment for a prosthetic appliance exceed the amount listed in the Schedule for an appliance having the same function.

DENTAL CHARGES NOT COVERED

The Fund does not cover:

1. Charges for procedures performed solely for cosmetic purposes.
2. Charges due to occupational related conditions or accidents and conditions covered by Workers' Compensation.
3. Charges for services or supplies that are not Medically Necessary.
4. Charges for services rendered or supplies furnished by a provider other than a Dentist.

5. Charges in excess of those generally made when there is no insurance/ coverage or in excess of the Maximum Allowable charges.
6. Charges that are paid under any other private or government dental or other (including, but not limited to Medicare) plan.
7. Dental Implants. However, the Fund will pay for dental implants, as an Out-of-Network benefit, where Medically Necessary due to bone loss in the jaw resulting from chemotherapy or radiation treatment.
8. Charges for services and supplies (a) received in a U.S. Government Hospital, (b) furnished elsewhere by or for the U.S. Government or (c) received in any other governmental Hospital or for other government-furnished care, unless the individual would have to pay the charges if not covered.
9. Charges due to an act of war, (either declared or undeclared) occurring while the individual is covered.
10. Charges for replacement of a lost or stolen prosthetic appliance.
11. Charges for crowns or appliances, if made solely for periodontal involvement and to stabilize or splint mobile teeth.
12. Charges for orthodontia, other than for the correction of (a) overbite or overjet of at least 4 millimeters; (b) maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp; (c) cross bite, or (d) medically necessary orthodontic items or services not covered under the Dental benefit.
13. Charges made for orthodontic treatment, performed when you are not eligible for Fund benefits.
14. Charges that fall under any motor vehicle policy, whether or not such policy is required by law, including but not limited to "No Fault" coverage.
15. Treatment of Temporomandibular Joint Syndrome (TMJ).
16. Charges for anesthesia, over and above the Fund allowance.
17. Charges which you or your family members are not legally required to pay.
18. Any other charges excluded under the general exclusions or dental exclusions in this SPD.

DENTAL CLAIM PROCEDURES

When visiting either a Network or Out-of-Network provider, please instruct the Dentist to use an ADA Universal Claim Form. The completed original claim form should then be returned, by the member or the Dentist, to Sele-Dent, Inc., One Huntington Quadrangle, Suite 1S03, Melville, NY 11747, Attn: Dental Claim Department, for determination of eligibility and benefit authorization.

All claims must be submitted for payment within one year of the date of service. If a claim is not submitted within that time limit, it will be denied.

For all services, payment of the claim will be made directly to you, unless you have assigned the payment to the Dentist, by completing the assignment section at the bottom of the claim form.

Sele-Dent, Inc. offers Local 282 participants 2 networks to locate participating providers. With over 5,000 Network dentists between both networks, participants should utilize a Sele-Dent dentist, when possible. **By utilizing a Network dentist, there are NO OUT-OF-POCKET EXPENSES for covered dental procedures, up to the $2,250 Individual Annual Calendar Year Maximum** that applies to covered individuals age 19 or older. In order to locate a Network provider, visit www.Sele-Dent.com. Or call 1-800-520-DENTAL (3368). In order to locate Elite Sele-Dent providers you must call the Sele-Dent office, this network is not listed on the web-site. If you have difficulty in locating a Network provider, please call the Sele-Dent office and our representatives will assist you in locating a dental location and/or specialty. This is a Freedom of Choice Plan; you may visit any dentist of your choice.

PENSIONER PRESCRIPTION DRUGS BENEFITS THROUGH HUMANA

If you are a Pensioner or Dependent who is eligible for Medicare and has Pensioner Benefits, your prescription drug benefit is provided by Humana. Eligible Pensioners/Dependents are referred by the Fund Office to the Retiree Benefit Manager, Labor First, upon enrollment in the Pensioner Benefits Plan.

Labor First will manage the enrollment process and assist you with any questions concerning ID cards, enrollment or subsidies. Specific questions about prescription drugs or the claim process should be addressed with Labor First. Please contact them at 1-855-766-3991.

PRESCRIPTION DRUG BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

(For acute drugs and maintenance drugs)

Prescription drug benefits are provided through CVS Caremark. Your Prescription ID card will be issued by CVS Caremark.

There are two ways for you to get your prescriptions through CVS Caremark:

1) CVS Caremark Retail Pharmacy Network Program

If you need a prescription filled immediately, have a local participating pharmacy fill your prescription. Simply present your CVS Caremark Prescription ID card to the participating pharmacist. You will pay the lesser of the following costs:

1. The cost of the medication, or
2. $10.00 (for Plan D, 20% co-coinsurance) for up to a 30-day supply of generic drugs, or
3. $20.00 (for Plan D, 20% co-insurance) for up to a 30-day supply for brand-name drugs.

Brand-name drugs with generic equivalents: If either you or your Physician requests a brand-name drug when a generic equivalent is available, you will have to pay the generic copay, plus the difference in cost between the brand-name and the generic medicine. If there is a clinical reason why the generic drug cannot be used, your Physician can request an exception for medical need

and provide medical/clinical information to support the request. If the request is approved, your copay will be the brand-name copay. If the drug requires preauthorization (see list on page 83), you will need to request preauthorization even if you have already received preauthorization for the drug in the past.

2) **Maintenance Choice Program (**CVS Caremark Mail Service Pharmacy or CVS Pharmacy Services)

If you are taking maintenance medications--these are medications you take on a daily basis--you **are required to** take advantage of the cost savings provided through the **Maintenance Choice Program.** For your convenience, you can either have your prescriptions mailed directly to your home or filled at a CVS Retail Pharmacy (only CVS Pharmacies qualify). Please contact CVS at 1-800-875-0867 for a mail service order form. Be sure to indicate your identification number shown on your CVS Caremark Prescription ID card when calling.

For the Maintenance Choice Program you will receive up to a 90-day supply of medication for a reduced copay. The co-payment is $20.00 for generic drugs and $40.00 for brand name drugs (For Plan D, 20% co-insurance).

If you have any questions about your prescription drug benefits or need to locate a Caremark network pharmacy, please call CVS Caremark at 1-855-722-6231 24 hours a day, seven days a week or visit www.caremark.com. Or, you can download the digital app for CVS Caremark for iPhone/iPad and Android through the app store.

DAW PENALTY

The Dispense as Written (DAW) Cost Share is applied when you or your physician requests a brand medication when a generic equivalent is available.

If you decide to use the brand medication, you'll pay the generic co-pay (or co-insurance under Plan D) plus the cost difference between the generic equivalent and brand medication.

GENERIC STEP THERAPY

Generic Step Therapy requires that a member try a generic drug or lower-cost brand-name alternative drug before higher-cost non-preferred drugs, unless special circumstances exist.

COVERED DRUGS

The following drugs are covered unless listed under "Exclusions" below:

- Federal legend drugs
- State restricted drugs
- Insulin
- Smoking deterrents
- Retin-A/Avita (for individuals age 26 and under only)
- Oral and transdermal contraceptives
- AIDS-related medications

COVERED DRUGS – PREAUTHORIZATION REQUIRED

The following drugs are covered provided that you submit a letter from the prescribing Physician stating that the prescription is Medically Necessary and the prescription is pre-authorized. Please contact CVS Caremark at 1-855-722-6231 to obtain a preauthorization for your medication or if you have any questions fulfilling this requirement.

- Erythroid stimulants (i.e., Epogen, Procrit)
- Injectable anti-inflammatory/anti-arthritics
- Interferons
- Leuprolide
- Myeloid stimulants (i.e., Neupogen)
- Compounded progesterone
- Retin-A/Avita (for individuals age 27 or older)
- Botox
- Growth hormones (limited to 24 months per lifetime)
- Amevive
- Copaxone

DISPENSING LIMITS

The amount of drug, including Insulin, that is to be dispensed per prescription or refill will be in quantities prescribed up to a 30-day supply through the Retail Pharmacy Network Program, and up to a 90-day supply through the Maintenance Choice Program.

EXCLUSIONS

The following are excluded from coverage.

- Non-federal/over-the-counter legend drugs (except those federally mandated by the Affordable Care Act).
- Fertility drugs - regardless of the purpose for which they are prescribed.
- Therapeutic devices or appliances including, but not limited to, support garments and other non-medical substances, regardless of their intended use.
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e., Rogaine, Propecia) or for cosmetic purposes only (i.e., Renova).
- Drugs labeled “Caution-limited by Federal law to investigational use”, or Experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the prescribing Physician, or any refill dispensed after one year from the prescribing Physician's original order.
- Charges for the administration or injection of any drug.
- Gene therapy.

NEW DRUGS

From time to time, the FDA approves new drugs. The Trustees reserve the right to decide if a new drug will be covered on a case-by-case basis. The Trustees may base their decision on, among other things, the industry practices and recommendation of the Fund's prescription benefit manager. From time to time, the Trustees will review these decisions and may reconsider a drug's exclusion.

If you have any questions about your prescription benefits, please call 1-855-722-6231. Emergency consultations are available 7 days a week 24 hours a day by calling this toll free number.

NON-INVASIVE CARDIAC AND VASCULAR EVALUATION

A complete NON-INVASIVE CARDIAC AND VASCULAR EVALUATION is available to all active Eligible Employees and their Dependents. Screening for heart attack, stroke, aneurysm, arrhythmias, electrical (conduction) abnormalities, or poor blood circulation through imaging techniques.

Unique outpatient facilities have been created to evaluate heart and blood vessel problems in a simple, painless and effective manner. Vascular Diagnostic Associates has such a facility and is located at 41-61 Kissena Boulevard, Flushing, New York 11355. The procedures used at Vascular Diagnostics are "non-invasive", which means that the tests are administered outside the body in order to determine what is going on inside. These painless and highly sophisticated techniques include: Cardiac Stress Test or Nuclear Stress test; ultrasound of the abdominal aorta for aneurysm; ultrasound of the carotid arteries (neck area) for stroke; evaluation of legs for blockages, body weight composition including BMI and meal plan; Cardiovascular Risk Profile including blood test for high cholesterol, high LDL/low HDL, high triglycerides, high glucose for diabetes. If necessary, more specialized testing, including 24-hour EKG (Holter Monitor), Echocardiogram (to look at the size, chambers, valves and motion of the heart).

In order to obtain this benefit, contact Vascular Diagnostic Associates at 1-718-886-0600 to arrange for an appointment to be scheduled from Monday to Friday between the hours of 9:00 a.m. to 5:00 p.m. Saturdays are scheduled twice per month for testing. Go to www.vasculardiagnostic.com for more information.

After the appointment has been confirmed, forms will be mailed to you that you are to complete together with instructions for preparation on the day of

the evaluation. The results of these tests will be sent to the patient and/or the patient's Physician.

This evaluation will be available once every twelve months based on the patient's Anniversary Date and will be paid for in full by the Fund, with no cost to you

EMPLOYEE ASSISTANCE PROGRAM

Participants in the Fund and their Dependents may obtain assistance from the Fund's Employee Assistance Program (EAP): Teamster Center Services (TCS).

TCS provides a variety of services related to the Fund's behavioral health benefits (substance abuse and mental health). These services include: advice and referral services, admission pre-certification and case management, a network of TCS-contracted treatment facilities and Substance Abuse Professional (SAP) services for participants with a commercial driver's license.

All of the services offered by TCS are free and confidential to Fund Participants, however, once a Participant or Dependent is admitted to any level of treatment or therapy, the costs for the services of that provider are subject to the Fund's benefit coverage limitations, including deductibles and copayments.

Advice and Referral: The TCS staff can assist you in locating appropriately licensed, in-network therapists and treatment programs.

Pre-certification: The Fund requires you to call TCS prior to any non-emergency inpatient admission for substance abuse or mental health treatment. Any admission that does not receive TCS certification will not be covered by the Fund. The Plan does not require precertification for outpatient behavioral health services, however, in is recommended that participants contact TCS prior to enrolling in any level of behavioral health treatment to discuss their situation with a TCS counselor and see if what levels of care and types of providers are recommended for particular case.

If your substance abuse or mental health condition is a medical emergency and requires immediate treatment, the pre-certification process can be satisfied by contacting TCS within 48 hours following your admission for treatment. Since you can obtain treatment in an emergency without prior approval of TCS, the Plan will not treat a request for pre-certification as an urgent claim within the meaning of the claim procedures.

BENEFITS MAY BE REDUCED BY 50%, UP TO $500, FOR EACH HOSPITAL ADMISSION THAT DOES NOT RECEIVE AUTHORIZATION.

TCS-Contracted Treatment Programs: TCS has directly contracted rate arrangements with numerous substance abuse treatment facilities; both locally and nationally, pursuant to which your out-of-pocket charges may be substantially lower or eliminated altogether. In addition, if you are admitted to a non-TCS facility, once you contact TCS on the first available business day, TCS may be able to arrange a transfer to, or may refer you to, a facility that has such an arrangement with TCS. Therefore, it is in your interest to contact TCS before any treatment to understand the amounts payable for substance abuse and mental health services under your Plan and to obtain the maximum benefits possible with the least out-of-pocket expense.

Substance Abuse Professional (SAP) Services: Many worksites that employ commercial drivers are subject to Federal Motor Carrier safety regulations. TCS provides the mandatory Substance Abuse Professional (SAP) evaluations, referral and compliance monitoring services that are required under those regulations

Teamster Center Services Contact Information:

Address: 121 West 27th Street, Suite 1100, New York, NY 10001

Telephone: 212-235-5003 or 800-433-4827

Office Hours: Monday through Thursday 8:30am to 4:30pm, and Fridays until 4:00pm.

TCS also provides a variety of other services, including:

- DOT Mandated Substance Abuse Professional (SAP) evaluations
- Benefit pre-certification, certification, and case management
- Advice and referral for:
  - qualified Physicians, specialists and Hospitals
  - emotional and behavior problems
  - mentally retarded or disturbed children and adults
  - disabled children and eligibility for special schooling
  - help with obtaining financial aid facilities
  - services for the aged
  - the chronically or terminally ill
  - rehabilitation, e.g., physiotherapy, or speech therapy
  - vocational guidance, job counseling and placement of the handicapped
  - social services available in the community
  - dental care
  - family and financial problems, e.g., help with child, home, loss of income, limitations of insurance benefits, referrals for financial counseling, marriage counseling, legal services and support groups
  - alcohol and drug abuse
  - health education

Please be advised that, although TCS provides advice and referral for the above services, not all referred or recommended services are covered under the Fund.

ANNUAL DIAGNOSTIC EXAMINATIONS

You and your Dependents may receive an annual examination through Professional Evaluation Medical Group (PEMG) based on your Anniversary Date, at no direct cost to you. PEMG will provide X-ray, laboratory and other diagnostic related tests, if requested by your personal Physician, **at no out-of-pocket expense to you**. The Fund will be billed directly.

The purpose of this benefit is to determine the presence of any health-related problems at early stages when treatment can be most effective.

PEMG's facilities are located at:

Nassau 380 South Broadway Hicksville, NY 11801	**Manhattan** 395 Hudson Street New York, NY 10017

The locations offer weekend, weekday and evening appointments. To make an appointment by phone, please call PEMG any weekday from 9:00 a.m. to 5:00 p.m. at (516) 935-4378.

All tests are administered during one visit, and the findings will be forwarded to your personal Physician. You may consult with PEMG's Medical Director at no charge.

CLAIMS AND APPEALS PROCEDURES

What Is A Claim?

A claim for benefits is a request for Fund benefits made in accordance with the Fund's reasonable claims procedures.

In general, under the Fund's rules, simple inquiries about benefits or eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Fund is also not considered a claim for benefits.

Types Of Claims

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal. The claims procedures for benefits will vary depending on whether your claim is a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Disability Claim. Read each section carefully to determine which procedures govern your claim. Reference to "days" refers to calendar days.

For rules regarding claims and appeals with respect to Vacation and Sick Leave Benefits, see page 96.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit for which the Fund requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Fund, prior approval of services is required for those services listed in the following sections of this SPD:

Anthem Blue Cross	Pages 50-55
Sele-Dent	Pages 77-81
CVS Caremark	Pages 81-84
EAP	Pages 85-86

IMPORTANT: IF YOU FAIL TO PRE-CERTIFY THESE SERVICES, PENALTIES WILL BE APPLIED AND YOU WILL RECEIVE A REDUCED BENEFIT.

For properly filed Pre-Service Claims, you and/or your Physician will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Fund (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than *5 days* after receipt of the claim of the proper procedures to be followed in filing a claim. You will receive notice of an improperly filed Pre-Service claim only if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

If an extension is needed because additional information is needed from you or your Physician, or due to improper filing, the extension notice will specify the information needed. In that case you and/or your Physician will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, or the claim is not re-filed, the Fund will have to decide the claim based on the information it has, and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Fund then has 15 days to decide your Pre-Service Claim and notify you of the determination.

Urgent Care Claims

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service claim 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 treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by the applicable claims payer by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different. The Fund will respond to you and/or your Physician with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you and/or your Physician will be notified as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. You and/or your Physician must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the specified information is received or the end of the period given for you to provide this information, whichever is earlier.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient Hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the *termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to the applicable pre-service or post-service timeframes.

Post-Service Claims

A Post-Service Claim is any claim that does not require that you obtain approval prior to obtaining the service, such as payment for covered services after a doctor visit.

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days of receipt of the claim. This period may be extended one time by the Fund for up to 15 days if the extension is necessary due to matters beyond the control of the Fund (unless the period is extended while the Fund awaits receipt of

information requested from you). If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which a decision will be made.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Fund will have to decide the claim based on the information it has, and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The organization responsible for paying the claim then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

How Is A Decision Regarding My Claim Made?

In making decisions regarding claims and appeals, the Fund and the Board of Trustees will apply the terms of the Fund and any applicable guidelines, rules and schedules, to ensure that benefit determinations are made in accordance with such documents, and applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal.

Neither the Fund nor the Trustees stand to gain in any way from denying a claim or an appeal. The Trustees receive no compensation from the Fund, and their decisions on appeals do not entitle them to any benefit from the Fund or their employers or the Union. To ensure that all claims and appeals for benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, neither the Fund nor the Trustees make decisions regarding hiring, compensation, termination, promotion, or other similar matters based on the likelihood that a person will support the denial of benefits.

When And How Claims Must Be Filed

All claims must be filed within 365 days following the date the charges were incurred. If you are a Medicare participant, claims should be filed within 365 days of the date on the Medicare Explanation of Benefits. Any claims not filed within these time periods may be denied.

Hospital/Medical Claims

Claims should be submitted directly to your local Blue Cross and Blue Shield in the state where you reside.

Filing Claims

There are no claim forms to submit for Network benefits, for most Hospital/Medical claims, Network optical, Network dental, annual physical and prescription drug benefits. Providers will submit claims directly to the applicable payer under the terms of their contracts.

When you need to submit a claim:

- ➢ Obtain a claim form and complete the Employee's portion of the claim form (including your name and Social Security Number or BCBS ID number, the patient's name, the patient's date of birth, if treatment is due to accident, accident details, including date, location, and nature of accident, Coordination of Benefits information including none, if applicable), ***and***
- ➢ Have your Physician either complete the Attending Physician's Statement section of the claim form (including Date of Service, CPT-4 code, ICD-9 (the diagnosis code), billed charge, Number of Units (for anesthesia and certain other claims), Federal Taxpayer Identification Number (TIN) of the provider, billing name and address, or attach an itemized bill containing this information.

Life Insurance Claims

Please refer to the to the Life Insurance section, at pags 35-36.

AD&D Benefit Claims

Please refer to the AD&D benefit section, at pages 37-42.

Weekly Accident & Sickness Benefits

Please refer to the Weekly Accident & Sickness benefit section, at pages 42-43.

Optical Benefits

Please refer to the Optical section, above, at pages 75-76.

Dental Benefits

Please refer to the Sele-Dent section, above, at pages 77-81.

Prescription Drug Benefits

Please refer to the CVS Caremark section above at pages 81-84.

Alcohol and Drug Abuse Benefits

Please refer to the EAP section, above, at pages 85-86.

Authorized Representatives

An authorized representative, such as your Spouse, may complete the claim form for you if you have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an **Urgent Care Claim** (defined on page 92) without your having to complete the special authorization form.

Notice Of Decision

If the Fund has all of the information needed to process the claim, the claim will be considered for payment and you will receive an Explanation of Benefits form. If your claim has been denied, the Explanation of Benefits form will provide written notice of the denial, whether denied in whole or in part, and will state:

- The specific reason(s) for the determination.

- The specific Fund provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits.
- Your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, that a copy of the rule is available upon request at no charge.
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or investigational, or other similar exclusion, that an explanation is available upon request at no charge.
- For Urgent Care Claims, the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

Request For Review Of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing, within *180 days* after you receive notice, to the Board of Trustees, c/o the Fund Manager, of denial, ***except*** for the following appeals which should be submitted to the applicable organization, as noted below. Information on where to submit appeals of Post-Service Claims denials will be indicated on the Explanation of Benefits.

Hospital Claims – Alicare Medical Management

Dental Claims – Sele-Dent, Inc.

Appeals involving Pre-Service, Concurrent or Urgent Care Claims may be made orally by calling Alicare Medical Management at 1-877-540-6663, or Sele-Dent at 1-800-520-3368 as applicable. Your written appeal should state the reason for your appeal. You may submit written comments, documents, records, and other information relating to the claim. If you choose to appeal, upon request you can receive, free of charge, access to and copies of all documents, records and other information relevant to your claim.

For appeals relating to Vacation and Sick Leave benefits, see pages 100-101. The Trustees or a designated committee of the Trustees will review your appeal.

Review Process

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the applicable claims payer on

your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. Be assured that no payments are made to any persons deciding appeals based on the number of appeals allowed or denied and no such person has any financial interest in the outcome of the appeal.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental), a health care professional who has appropriate training and experience in the relevant field of medicine will be consulted.

Timing Of Notice Of Decision On Review

Pre-Service Claims: You will be sent a notice of decision on review within 30 days of receipt of the appeal.

Urgent Care Claims: You will be sent a notice of a decision on review within 72 hours of receipt of the appeal.

Post-Service Claims: Ordinarily, decisions on appeals involving Post-Service Claims will be made no later than the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered no later than the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary, as well as the reason for the extension and the date the appeal decision will be made. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Disability Claims: The decision will be made in the same manner as for Post-Service Claims.

Concurrent Claims: The decision will be made prior to the termination of any benefit.

Notice Of Decision On Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination.
- The specific plan provision(s) on which the determination is based.
- That you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- That you have the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was Experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

External Review

If the Fund denies your claim for benefits, your claim may be eligible for external review. You must file a request for external review with the Fund within 4 months after the date you receive notice of the Trustees' decision denying your appeal. The Fund will conduct a preliminary review and will notify you within 5 business days whether you are eligible for external review, or whether the Fund needs more information or materials from you to make its decision. If the Fund does need more information or materials, you will have until the later of the end of the 4-month period that began on the day you received notice of the Board of Trustees' denial or within the 48-hour period following the day you were notified that more information or materials were required.

If your claim is accepted for external review, the Fund will refer your claim to an Independent Review Organization (IRO), and the IRO will notify you. You will then have 10 business days to provide the IRO with any additional information you want it to consider. The IRO is not required to accept any information from you more than 10 business days after you receive notice, but it may decide to do so. The Fund will have 5 business days after your claim is assigned to an IRO within which to provide the IRO with all the documents and information to be considered in reviewing your claim. If the Fund fails to do so, the IRO may decide to reverse the benefit denial, in which case it will notify you and the Fund within one business day after making this decision. The IRO will forward to the Fund any information you provide. The Fund may then decide to reverse its denial, in which case the Fund will notify you within 1 business day of such a decision.

If the denial of your claim is not reversed as described in the paragraph above, the IRO will provide you and the Fund with written notice of its decision on your claim within 45 days after it receives the request for external review. The IRO is not bound by the Fund's decision or conclusions regarding your claim. The notice will contain:

- A description of the reason for the request for external review;
- The date the IRO received the request from the Fund;
- References to the evidence and documentation used in reviewing the claim;
- A discussion of the reason(s) for the decision;
- A statement that the IRO's decision is binding except to the extent other remedies are available to you or the Fund under State or Federal law; and
- A statement that judicial review of the decision may be available to you.

Once the IRO notifies the Fund that it has reversed the denial of benefits, the Fund must immediately provide coverage or payment for the claim.

The IRO must maintain records of your claim for six years and make the records available to you for inspection on your request.

Expedited External Review:

You are entitled to request an expedited external review without first appealing to the Board of Trustees if you want to appeal an Urgent Care Claim after the Fund's initial denial of a Pre-Service Claim and if the Claim involves a medical condition for which the time frame for an appeal to the Board of Trustees would seriously jeopardize your life or health or your ability to regain maximum function. If the Board of Trustees has already denied an appeal for such a Claim, you are still entitled to request an expedited external review, and are also entitled to make such a request if the decision concerns an admission, availability of care, or continued stay for which you have received emergency services and have not been discharged from a facility. You are also entitled to, free of charge, any new or additional evidence considered by the Fund, relied upon or generated by the plan in the denial, and any new or additional rationale for the denial.

Once you have requested an expedited external review, the Fund will immediately determine whether your claim is eligible for expedited external review and immediately send you notice of its decision or whether the Fund needs more information or materials from you to make its decision. If your claim is eligible for expedited external review, the Fund will assign the claim to an IRO and expeditiously provide the IRO all documents and information considered in denying the claim. The IRO must make a decision no later than 72 hours after it receives the request. If the notice is not in writing, the IRO must provide written confirmation to you and the Fund within 48 hours after providing the initial notice.

You are advised that the IRO's decision is binding, except to the extent it is reviewable under Federal or state law.

If Your Appeal Is Denied

No Participant, Dependent, Beneficiary, or other person making a claim under this Fund may obtain judicial review of a denial of benefits unless both of the following are satisfied:

- The person making the claim has exhausted the Fund's claims and appeal procedures that are described here, and the Board of Trustees (or, if applicable, an IRO) has denied the claim in whole or in part; and
- The lawsuit is filed no more than 12 months after the date on which the Board of Trustees (or, if applicable, an IRO) issued its decision on the request for review (or external review).

Any legal or equitable action for benefits under the Fund must be brought in the United States District Court for the Eastern District of New York.

VACATION AND SICK LEAVE BENEFITS

If your Employer's Collective Bargaining Agreement requires Vacation and Sick Leave Contributions (as defined below) to be made on your behalf, you will be eligible for Vacation and Sick Leave benefits as described below.

VACATION AND SICK LEAVE DEFINITIONS

These definitions apply specifically to Vacation and Sick Leave benefits:

1. Benefit Period

"Benefit Period" means the period from July 1st through June 30th.

2. Vacation and Sick Leave Contributions

"Vacation and Sick Leave Contributions" as used herein means Employer Contributions to this Fund for Vacation and Sick Leave benefits in accordance with a Collective Bargaining Agreement.

3. Vacation and Sick Leave Participant

"Vacation and Sick Leave Participant" means an Employee who has worked in Covered Employment during any part of a Benefit Period and for whom Vacation and Sick Leave Contributions have actually been made.

VACATION AND SICK LEAVE RULES AND REGULATIONS

1. Participation

An Employee who is engaged in Covered Employment for which Vacation and Sick Leave Contributions are received shall become a Vacation and Sick Leave Participant as of the first day of the month following the receipt of such Vacation and Sick Leave Contributions. An individual account shall be established in the books and records of the Fund in the name of each Vacation and Sick Leave Participant and shall be credited with the Vacation and Sick Leave Contributions received on behalf of the Vacation and Sick Leave Participant.

2. Merger, Consolidation or Transfer

In the event of any merger or consolidation with, or transfer of assets or liabilities to any other Fund, the amount of Vacation and Sick Leave benefits which an Employee would receive upon a termination of the Fund immediately after such merger, consolidation or transfer shall be no less than the benefit he would have been entitled to receive immediately before the merger, consolidation, or transfer, if the Fund had been terminated.

3. Benefit Upon Termination

In the event of the complete discontinuation of Vacation and Sick Leave benefits or in the event of the termination of the Fund, the assets then remaining, after providing for the expenses of the Fund and for the payment of any Vacation and Sick Leave benefits due for the preceding Benefit Period, shall be distributed among the Vacation and Sick Leave Participants. Each Vacation and Sick Leave Participant (or his or her beneficiary) shall receive a portion of the total remaining assets based on the ratio of the Vacation and Sick Leave Contributions received in his or her account since the end of the preceding Benefit Period. No part of the assets shall be returned to any Employer or inure to the benefit of any Employer or the Union.

In the event the assets are insufficient to pay the amounts provided for in this section, the Trustees shall, in their discretion, allocate such assets in a fair and equitable fashion among the Vacation and Sick Leave Participants (or beneficiaries) and any creditors of the Fund.

4. Missing Vacation and Sick Leave Participant or Beneficiary

If, after making reasonable efforts, the Fund is unable to locate a Vacation and Sick Leave Participant or beneficiary to whom payment is due, that Vacation and Sick Leave Participant's or beneficiary's benefit may be forfeited to the Fund. Reasonable efforts to locate a missing Vacation and Sick Leave Participant or beneficiary may include contacting the designated beneficiary, conducting Google or other Internet searches, and reviewing the Fund Office's records. The determination of whether a Vacation and Sick Leave Participant or beneficiary is unable to be located and whether his benefit should be forfeited to the Fund rests within the sole and exclusive discretion of the Board of Trustees. If the missing Vacation and Sick Leave Participant or beneficiary to whom payment was due subsequently submits a valid claim for the benefit, the benefit will be reinstated in the amount that was forfeited.

5. New Employers

If an Employer is sold, merged or otherwise undergoes a change of company identity, the successor company shall participate as to the Employees who are Vacation and Sick Leave Participants just as if it were the original company, provided the successor company remains a Contributing Employer.

VACATION AND SICK LEAVE FREQUENTLY ASKED QUESTIONS

Following are frequently asked questions and answers regarding Vacation and Sick Leave benefits:

1. How do I know if I am eligible to receive Vacation and Sick Leave benefits?

If you are working for an Employer that makes Vacation and Sick Leave Contributions on your behalf pursuant to a Collective Bargaining Agreement with Local 282, you are eligible to receive Vacation and Sick Leave Benefits.

Please contact the Fund Office if you have any questions about whether your Employer is obligated to make Vacation and Sick Leave Contributions on your behalf.

2. What information do I need to provide to the Fund Office?

Please make sure that the Fund Office has your current address and other contact information, and that you have filed a completed designated beneficiary form with the Fund Office in the event you die before your benefits become payable.

3. What Employer industries currently make Vacation and Sick Leave Contributions?

As of March 26, 2013, Employers In the following Industries make Vacation and Sick Leave Contributions : (1) Nassau/Suffolk Heavy Construction, Excavating & Asphalt, (2) Nassau /Suffolk Ready-Mix, (3) New York City Heavy Construction, Excavation & Asphalt, (4) Metropolitan Truckers, (5) Building Material Contractors, (6) Building Material Suppliers, and (7) Demolition.

4. Who pays the cost of the Vacation and Sick Leave benefits?

The cost of the Vacation and Sick Leave Benefits is paid by Vacation and Sick Leave Contributions under Collective Bargaining Agreements, and the investment income generated thereon. You are not permitted to make contributions to the Fund. Your account may be subject to adjustment for administrative expenses.

5. On what date is the Annual Valuation of Vacation and Sick Leave benefits?

Vacation and Sick Leave Benefits are valued on June 30th of each year. The Board of Trustees reserves the right to change the annual valuation date.

6. How often are Vacation and Sick Leave benefits paid and what time period is covered by each benefit check?

The Fund issues Vacation and Sick Leave benefit checks once per year, and twice per year where Vacation and Sick Leave Contributions are received on or between October 1st and February 28th (February 29th in leap years) for the period ending on the prior June 30th. Benefit checks and accompanying benefit statements are generally issued in the second half of each November, and in the second half of March when Vacation and Sick Leave Contributions are received on or between September 30th and February 28th for the period ending on the prior June 30th. However, the dates on which benefit checks and statements are mailed may vary from year to year.

Your benefit check consists of Vacation and Sick Leave Contributions received by the Fund on your behalf for hours worked in Covered Employment during the period from July 1st to June 30th of that year, as well as any adjustments for prior years based on a payroll audit or late-made contributions, and may be subject to adjustment for administrative expenses. In addition, the payments must have been received and processed by the Fund between October 1st and September 30th in order to be included in the benefit check you receive the following November. For example, contributions for hours worked during the period from July 1st, 2019 to June 30th, 2020 must be posted to your account between October 1st, 2019 and September 30th, 2020 in order to be included in the benefit check you receive in November 2020. If any contributions for that year are posted to your account on or between October 1st, 2020 and February 28th, 2021, you will receive those benefits in March 2021.

7. What is an example of the amounts included in my benefit check?

As an example, your 2020 benefit check (generally payable sometime in November of 2020) will include Vacation and Sick Leave Contributions received by the Fund Office on your behalf for your work in Covered Employment during the period between July 1, 2019 and June 30, 2020. In addition, if an audit of your Employer for periods prior to July 1, 2019 reflected an underpayment of contributions on your behalf and your Employer corrected the underpayment by payment before September 30, 2020, your November 2020 benefit payment will be increased to reflect your Employer's payment of the audit deficiency. If your Employer corrects the underpayment between October 1, 2020 and February 28, 2021, the amount would not be included in your November, 2020 check, but you would receive a check reflecting that payment in March, 2021. Similarly, if an audit of your Employer for periods prior to July 1, 2019 reflected an overpayment of contributions on your behalf for that period and the Trustees

have accepted the overpayment, your 2019 benefit will be reduced to reflect your Employer's prior overpayment. Finally, your benefit may be adjusted for administrative expenses.

8. What information is included in the benefit statements that accompany benefit checks?

The annual statement includes the number of hours you worked in Covered Employment that your Employer reported for the period from July 1st through June 30th and any adjustments as a result of an audit or late-made payment for prior periods or for administrative expenses. The statement also includes the hourly contribution rate set forth in the Collective Bargaining Agreement covering your work.

In addition to your annual Vacation and Sick Leave benefit statement, you receive monthly and quarterly statements from the Fund Office reflecting all hours reported to the Funds on your behalf for the period covered by the statement. It is important that you review the monthly and quarterly statements carefully and immediately report any discrepancies in writing to the Fund Office, with documentation supporting your claim that your Employer failed to make all the required contributions.

9. What does a minus sign on benefit statements indicate?

A minus sign on your benefit statement indicates that a payroll audit of your Employer showed that overpayments of contributions were made on your behalf in the past and paid to you in a prior year's benefit check, and that the contributions made to your account for the period from July 1st through June 30th were reduced by the amount of the previous overpayment.

10. What if additional contributions for the period covered by the annual benefit check are made to the Fund on my behalf after both the November and March benefit checks have been issued?

If your Employer makes additional payments on your behalf for a July 1st through June 30th period after both November and March benefit checks have been issued for that period (either as a result of untimely payments or audit findings), those amounts will be credited to your account and will be included in a check for the following year.

11. Where does the Fund Office send benefit checks?

The Fund Office sends benefit checks to your last known address. Thus, it is extremely important that you notify the Fund Office immediately if you have a change of address.

12. Does the Fund deduct taxes from my benefit?

The Fund does not deduct taxes from your Vacation and Sick Leave benefit. Instead your Employer is required to make payroll tax deductions and withhold applicable income taxes from your wages before it makes the contributions to the Fund.

13. What if I die before I receive all of my benefits?

Your remaining benefits will be paid to your designated beneficiary. Please make sure that you have submitted a completed designated beneficiary form

to the Fund Office. If your designated beneficiary has pre-deceased you or if you have no designated beneficiary, your benefit will be paid to the following persons, if then living, in the following order: (1) your spouse, (2) your child or children, (3) your parent(s), (4) your sibling(s), or (5) your estate.

The designated beneficiary form must be submitted to the Fund before the Vacation and Sick Leave Participant's death. You may change your beneficiary(ies) without consent of the beneficiary(ies) at any time by completing and submitting a new designated beneficiary form to the Fund Office. The Trustees shall be the sole judges of the effectiveness of the designation or change thereof.

14. Are my benefits subject to garnishment?

Your benefits are subject to garnishment, and the Fund is required by law to honor any court order, garnishment, or other judgment of a court of law or notice of a child support enforcement agency.

15. Are there any other ways in which my benefit might be forfeited?

If you commit fraud, you will forfeit all of your benefits until the benefits fraudulently obtained are fully repaid. Examples of fraud include altering a check or knowingly cashing a voided check. In addition, the Fund may pursue legal action against you if you commit fraud.

16. What should I do if I believe I am entitled to Vacation and Sick Leave benefits but did not receive a check, or if I believe that I am entitled to greater benefits than reflected in my benefit check?

Ordinarily you do not need to file a claim to receive your Vacation and Sick Leave benefits, as your benefits are paid to you automatically once per year. However, if you did not receive any Vacation and Sick Leave benefits or if you believe you were due additional Vacation and Sick Leave benefits, you must file a written claim with the Fund Office. No dispute will be resolved in person or over the telephone. Your claim for additional Vacation and Sick Leave benefits must be in writing and must be made within 120 days after the benefit checks were mailed. Your claim should be accompanied by any documents that support your claim for benefits, such as pay stubs or other documentation.

A decision regarding the claim will be made by the Fund Office within 90 days from the date the claim is received by the Fund Office, unless it is determined that special circumstances require an extension of time for consideration of the claim, not to exceed an additional 90 days. If such an extension is required, written notice of the extension will be furnished to you prior to expiration of the initial 90-day period. The notice of extension shall include the special circumstances requiring the extension of time and the date by which the Fund Office expects to make a determination with respect to the claim. If the extension is required on account of your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the date on which you respond to the Fund Office's request for more information.

If the Fund Office denies your claim, in whole or in part, you will be provided with written notice of the determination. The notice shall include (i) the specific reason(s) for the adverse benefit determination, with reference to the specific

Plan provisions on which the determination is based, (ii) a description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such material or information is necessary), (iii) a description of the Fund's appeal procedures and the applicable time limits, and (iv) a statement of your right to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") following an adverse benefit determination on appeal.

17. Can I appeal an adverse ruling on a claim?

If the Fund Office denies your claim for benefits, you, or your authorized representative, may appeal the denial of the claim to the Board of Trustees. Your appeal must be in writing and must be sent to the Trustees within 60 days after receipt of the notice of denial of your claim. In connection with the appeal, you or your authorized representative may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to and copies of all documents, records, and other information relevant to your claim. The Trustees will give your claim a full and fair review, which will take into account all comments, documents, records and other information submitted by you in support of your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Trustees will make a decision on your appeal by the date of the meeting of the Board of Trustees that immediately follows receipt of your appeal, unless your appeal is filed within 30 days preceding the date of such meeting. In such case, a decision will be made by no later than the date of the second meeting following receipt of your appeal. If special circumstances require a further extension of time for processing, a decision shall be made not later than the third meeting of the Board of Trustees following receipt of your appeal. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide you with written notice of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. You will be notified in writing of the decision on appeal as soon as possible, but no later than 5 days after the decision on appeal is made. If your appeal is denied, in whole or in part, the notice shall include: (i) the specific reason(s) for the adverse benefit determination, with reference to the specific plan provisions on which the determination is based, (ii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim, and (iii) a statement of your right to bring a civil action under ERISA. The Trustees' decision on appeal shall be final and binding on all parties.

CONTACT INFORMATION

WHAT	WHY	WHERE
Local 282 Trust Funds Member Services	For questions about your benefits or eligibility	**516-488-2822 or 718-343-3322 Monday through Friday 9:00AM to 4:30PM www.teamsterslocal282.com**
BLUECARD® Program	Get Network benefits while you are away from home: Locate a provider outside your Anthem network service area	**800-810-BLUE (2583) 24 hours a day, 7 days a week www.bcbs.com**
General Vision Services (GVS)	Any questions about your vision benefits or assistance locating a GVS network provider	**800-847-4661 Monday through Friday 9:00AM to 5:00PM www.generalvision.com**
Vision Screening	Any questions about your vision benefits or assistance locating a network provider	**800-652-0063 Monday through Friday 9:00AM to 5:00PM www.visionscreeninginc.com**
CPS Optical	Any questions about your vision benefits or assistance locating a network provider	**888-675-3137 or 212-675-5745 Monday through Friday 9:00AM to 5:00PM www.cpsoptical.com**
GHS	For questions about hearing aid benefits	**888-899-1447**
CVS Caremark	Any questions about prescription drug benefits or assistance locating a CVS network pharmacy (active Participants only; for Pensioner drug benefits, contact Labor First, below)	**855-722-6231 24 hours a day, 7 days a week www.caremark.com**
Alicare Medical Management	Pre-certification of Hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	**Alicare Medical Management 877-540-6663 24 hours a day, 7 days a week**
Labor First	Any questions concerning claims for Retirees eligible for Medicare	**855-766-3991 (Toll Free) or 856-316-7226 Monday through Friday 8:30AM to 5:30PM**
Sele-Dent	Any questions about your dental benefits or assistance locating a Sele-Dent network provider	**800-520-3368 Monday through Friday 8:00AM to 4:00PM www.sele-dent.com**
Professional Evaluation Medical Group (PEMG)	Annual Diagnostic Exams	**516-935-4378 Monday through Friday 9:00AM to 5:00PM**

WHAT	WHY	WHERE
Teamster Center Services/EAP	Call TCS prior to admission (in-patient or out-patient) for substance abuse or mental health treatment	**212-235-5003 or 800-433-4827 Monday through Friday 8:30AM to 4:30PM**
Vascular Diagnostic Associates	Screening for heart attack, stroke, aneurysm, arrhythmias, electrical (conduction) abnormalities, or poor blood circulation through imaging techniques	**718-886-0600 Monday through Friday 9:00AM to 5:00PM www.vasculardiagnostic.com**

NOTICE OF PRIVACY PRACTICES

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

THIS NOTICE ALSO APPLIES TO YOUR SPOUSE AND OTHER DEPENDENTS. PLEASE SHARE IT WITH THEM.

Introduction

As a group health plan, the Local 282 Welfare Fund ("the Fund") is a covered entity within the meaning of the Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA". Under HIPAA the Fund is legally required to provide you, the participant, with notice of our legal duties and privacy practices with respect to protected health information ("PHI"). PHI includes any individually identifiable information that relates to your physical or mental health, the health care that you have received or payment for your health care, including name, address, date of birth and Social Security number.

We are legally required to maintain the privacy of your PHI. The primary purpose of this notice is to describe the legally permitted uses and disclosures of PHI, some of which may not apply to this Fund in practice. This notice also describes your right to access and control your PHI.

We are required to abide by the terms of this Notice of Privacy Practices ("Notice"). However, we reserve the right to change the terms of this or any subsequent Notice at any time. If we elect to make a change, the revised Notice will be effective for all PHI that we maintain at that time. Within 60 days of any material revision of our privacy practices we will distribute a new Notice. Additionally, you may contact the Fund directly at any time to obtain a copy of the most recent Notice, or visit our website at www.teamsterslocal282.com to download the current Notice.

This Notice is effective September 23, 2013.

Permitted Uses And Disclosures

We use and may disclose your PHI[1] in connection with your receiving treatment, our payment for such treatment and for health care operations. Generally we will make every effort to disclose only the minimum necessary amount of PHI to achieve the purpose of the use or disclosure.

Treatment: means the provision, coordination or management of your health care. As a health plan, while we do not provide treatment, we may use or disclose your PHI to support the provision, coordination or management of your care. For example, we may disclose the fact that you are eligible for benefits to a provider who contacts us to verify your eligibility.

Payment: means activities in connection with processing claims for your health care. We may need to use or disclose your PHI to determine eligibility for coverage, medical necessity and for utilization review activities. For example, we could disclose your PHI to physicians engaged by the Fund for their medical

[1] Except for psychotherapy notes, which require your specific authorization. The Fund does not routinely use or disclose psychotherapy notes.

expertise in order to help us determine medical necessity and eligibility for coverage.

We may disclose your PHI to third parties who are known as "Business Associates" that perform various activities (e.g., hospital pre-authorization, case management) for us. In such circumstances, we will have a written contract with the Business Associate, which requires the Business Associate to protect the privacy of your PHI.

We may disclose your PHI, including your eligibility for health benefits and specific claim information to other covered entities such as your spouse's health plan, in order for us to coordinate benefits between this Fund and/or another plan under which you may have coverage.

We may also disclose your PHI and your dependents' PHI, on explanations of benefit forms ("EOBs") and other payment-related correspondence, such as pre-certifications, which are sent to you.

If you appeal a benefit determination on behalf of a Dependent, or if a close family member appeals a determination on behalf of you or one of your Dependents, we may disclose PHI related to that appeal to you or that close family member. If you appeal a benefit determination and you designate an Authorized Representative to act on your behalf, we will disclose PHI related to that appeal to that Authorized Representative.

Health Care Operations: generally means general administrative and business functions that the Fund must perform in order to function as a health plan. For example, we may need to review your PHI as part of the Fund's efforts to uncover instances of provider abuse and fraud.

Reminders: We may use your PHI to provide you with reminders. For example, we may use your child's date of birth to remind you that you may purchase continuation coverage for your child who would otherwise lose coverage under the Fund due to attaining a specified age.

Treatment Alternatives: We may use your PHI to inform you about treatment alternatives.

Health-Related Benefits And Services: We may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Disclosure To Trustees Of The Fund: We may disclose your PHI to the Trustees of the Fund in connection with appeals that you file following a denial of a benefit claim or a partial payment. Trustees may also receive PHI if necessary for them to fulfill their fiduciary duties with respect to the Fund. Such disclosures will be the minimum necessary to achieve the purpose of the use or disclosure. In accordance with the Fund documents, such Trustees must agree not to use or disclose PHI other than as permitted in this Notice or as required by law, not to use or disclose the PHI with respect to any employment-related actions or decisions, or with respect to any other benefit plan maintained by the Trustees.

Trustees may also receive your PHI from any HMO the Fund may contract with, if such disclosure is required for the Trustees to fulfill their duties.

Family Members Involved In Your Health Care Or Payment Of Your Health Care: Unless we agree to your request that we not do so, we may disclose to a spouse, or other member of your immediate family involved in your health care or payment of your health care PHI related to such person's involvement. For instance, your spouse may be told whether or not a specific claim has been paid. We may also disclose your PHI to any authorized public or private entities assisting in disaster relief efforts.

Personal Representatives: We may disclose your PHI to your personal representative in accordance with applicable state law or the HIPAA Privacy Rule. In addition, a personal representative can exercise your personal rights with respect to PHI. You are automatically the personal representative of your unemancipated child, except that all requests for PHI related to children over age 12 must be in writing, other than payment.

Required By Law: We may use or disclose your PHI to the extent that we are required to do so by federal, state or local law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of preventing or controlling disease (including communicable diseases), injury or disability. If directed by the public health authority, we may also disclose your PHI to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse Or Neglect: We may disclose your PHI to any public health authority authorized by law to receive reports of child abuse or neglect. In addition, if we reasonably believe that you have been a victim of abuse, neglect or domestic violence we may disclose your PHI to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food And Drug Administration: Our Prescription Benefits Manager may disclose your PHI to a person or company subject to the jurisdiction of the Food and Drug Administration ("FDA") with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, we may disclose your PHI under certain conditions in response to a subpoena, discovery request or other lawful process, in which case, reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to this disclosure.

Law Enforcement: We may also disclose your PHI, if requested by a law enforcement official as part of certain law enforcement activities.

Coroners, Funeral Directors, And Organ Donation: We may disclose your PHI to a coroner or medical examiner for identification purposes, or other duties authorized by law. We may also disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

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

Military Activity And National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials conducting national security and intelligence activities including the protection of the President.

Workers' Compensation: We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the institution or law enforcement official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

Required Uses And Disclosures: We must make disclosures to you and to the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.

Authorization For Other Uses And Disclosures Of Your PHI: Most uses and disclosures of psychotherapy notes relating to you, uses and disclosures of your PHI for marketing purposes, and disclosures that constitute sales of your PHI require your authorization. Other uses and disclosures of your PHI not described in this notice will be made only with your written authorization, unless otherwise permitted by law as described above. If you authorize us to use or disclose your PHI for purposes other than set forth in the Notice, you may revoke that authorization, in writing, at any time, except to the extent that we have already taken action based upon the authorization. Thereafter, we will no longer use or disclose your PHI for the reasons covered by your written authorization. The Fund will not use or disclose your PHI that is "genetic information" for "underwriting" purposes, as defined by the Genetic Information Nondiscrimination Act of 2008.

Your Rights

Right To Inspect And Copy: As long as we maintain it, you may inspect and obtain a copy of your PHI that is contained in a Designated Record Set. "Designated Record Set" means a group of records that comprise the enrollment, payment, claims adjudication, case or medical management record systems maintained by or for the Fund. If the Fund uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct (in a signed written request) that such PHI be sent to another person or entity.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

We may decide to deny access to your PHI if it is determined that the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or if the records make reference to another person (other than a health care provider) and the requested access would likely cause substantial harm to the other person. Depending on the circumstances, that decision to deny access may be reviewable by a licensed health professional who was not involved in the initial denial of access and who has been designated by the Fund to act as a reviewing official.

To request access to inspect and/or obtain a copy of any of your PHI, you must submit your request in writing to our Privacy Officer at the address below indicating the specific information requested. If you request a copy, please indicate in which form you want to receive it (i.e., paper or electronic). We shall impose a fee to cover the costs of copying the requested PHI, supplies for creating the paper copy or electronic media, the cost of preparing a summary of your PHI, and postage.

Right To Request A Restriction Of Your PHI: You may ask us not to use or disclose any part of your PHI for the foregoing purposes. You may also request that we not disclose your PHI to your spouse or members of your immediate family who may be involved in your care or for notification purposes as described above.

We are not required to agree to a restriction that you may request. However, if we do agree to the request, we will not use or disclose your PHI to your spouse or family member in violation of that restriction unless it is needed to provide emergency treatment or we terminate the restriction with or without your agreement. If you do not agree to the termination, the restriction will continue to apply to PHI created or received prior to our notice to you of our termination of the restriction. To request a restriction you must write to our Privacy Officer at the address below indicating what information you want to restrict, whether you want to restrict use, disclosure or both, and to whom you want the restriction to apply.

Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location: You may request in writing, and we must accommodate your reasonable request, to receive communications of PHI, including an Explanation of Benefits ("EOB") from us, at an alternative location. For example, you can ask that we only contact you at

work or by fax or at another address if you believe that disclosure of all or any protected health information could endanger you. Please direct your written request to our Privacy Officer at the address below.

Right To Amend Your PHI: If you believe that PHI that we have about you is incorrect or incomplete, you may request it to be amended. Your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. You have this right as long as the Fund maintains your PHI in a designated record set. We will make an amendment to PHI we created or if you demonstrate that the person or entity that created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we determine is accurate and complete.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Did not originate with us, unless the person or entity that originate the PHI is no longer available to make the amendment;
- Is not contained in the records maintained by the Fund;
- Is not part of the information which you would be legally permitted to inspect and copy;
- Is accurate and complete.

If we deny your request for amendment, you have the right to file a written statement of disagreement with us or you can request us to include your request for amendment along with the information sought to be amended if and when we disclose it in the future. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right To An Accounting Of Disclosures: You have the right to request an accounting or list of disclosures of your PHI made by the Fund or its Business Associates. We are required to comply with your request except with respect to disclosures:

- Made in connection with your receiving treatment, our payment for such treatment and for health care operations;
- Made to you regarding your own PHI;
- Pursuant to your written authorization;
- To a person involved in your care or for other permitted notification purposes;
- For national security or intelligence purposes;
- That are part of a limited data set; and
- To correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer. You have the right to receive an accounting of disclosures of PHI made within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Your request should indicate the form in which you want the list (e.g., paper or electronic). The first request within

a 12-month period will be free of charge. For additional requests within the 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

Right to Receive Notice of Certain Breaches of PHI: If your "unsecured" PHI is accessed, acquired, used or disclosed in a manner that is considered a breach and not permitted under the HIPAA privacy rules we will notify you. Unsecured PHI is PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through certain specified technologies and methodologies.

Right To Obtain A Paper Copy Of This Notice: You may request a paper copy of our Notice at any time, even if you have previously agreed to accept this Notice electronically. Additionally, you may visit our website at www.teamsterslocal282.com to view or download the current Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit your complaint in writing to our Privacy Officer at the address below. We will not retaliate against you for filing a complaint.

For Questions Or Requests

If you have any questions regarding this Notice or would like to submit a written request as described above, please contact:

Privacy Officer
Local 282 Welfare Fund
2500 Marcus Avenue
Lake Success, NY 11042

(516) 488-2822
(718) 343-3322

GENERAL PROVISIONS FOR ALL BENEFITS

1. No Right to Assets

No person other than the Trustees shall have the right, title or interest in any of the income or property of any funds received or held for the account of the Fund, and no person shall have any right to benefits provided by the Fund except as expressly provided herein.

2. Non-Reversion

It is expressly understood that in no event shall any of the corpus or assets of the Fund revert to the Employers or be subject to any claims of any kind or nature by the Employers, except for the return of an erroneous contribution within the time limits prescribed by law and the Fund's refund policy.

3. Limitation of Liability

Except for liabilities that may result from provisions of ERISA, nothing in this Fund shall be construed to impose any obligation to contribute beyond the

obligation of the Employer to make contributions as stipulated in its Collective Bargaining Agreement.

There shall be no liability upon the Trustees individually, or collectively, or upon the Union to provide the benefits established by this Fund, if the Fund does not have assets to make such payments.

PLAN INFORMATION

Name of Plan: Local 282 Welfare Trust Fund

Plan Sponsor: Board of Trustees
Local 282 Welfare Trust Fund
2500 Marcus Avenue
Lake Success, NY 11042
(516) 488-2822
(718) 343-3322

Employer Identification Number (EIN) Assigned By IRS: 11-6244552

Plan Number: 501

Plan Year: March 1 through February 28

Type of Plan
This is an Employee welfare benefit, providing group health plan benefits (hospital, surgical, medical, dental, optical, and prescription drug benefits), life insurance, accidental death, dismemberment and loss of sight benefits, vacation and sick leave, and weekly accident and sickness insurance benefits.

Type of Administration
The Local 282 Welfare Trust Fund is administered by a joint Board of Trustees consisting of five Union Trustees and five Employer Trustees. The names, titles, and business addresses of the Trustees are:

UNION TRUSTEES:	EMPLOYER TRUSTEES:
Mr. Thomas Gesualdi President Local 282 I.B. of T 2500 Marcus Avenue Lake Success, NY 11042	Mr. Frank H. Finkel Branch Manager Ferguson Enterprises 57-22 49th Street Maspeth, NY 11378-2099
Mr. Louis Bisignano Secretary-Treasurer Local 282 I.B. of T. 2500 Marcus Avenue Lake Success, NY 11042	Mr. Joseph Ferrara Sr. President/CEO Ferrara Mason Materials 89-19 Liberty Avenue Ozone Park, NY 11417
Mr. Michael O'Toole Vice President Local 282 I. B. of T. 2500 Marcus Avenue Lake Success, NY 11042	Mr. Marc Herbst L.I. Contractors Assoc. 150 Motor Parkway Suite 307 Hauppauge, NY 11788
Mr. Darin Jeffers Recording Secretary Local 282 I. B. of T. 2500 Marcus Avenue Lake Success, NY 11042	Mr. Thomas Corbett Shamrock Materials Corp. 68 Signal Hill Road Staten Island, NY 10301
Mr. Michael C. Bourgal Union Trustee Local 282 I. B. of T. 2500 Marcus Avenue Lake Success, NY 11042	

The Trustees may be contacted either at their business address or c/o Local 282 Welfare Trust Fund, 2500 Marcus Avenue, Lake Success, New York 11042.

Plan Administrator
Board of Trustees
Local 282 Welfare Trust Fund
2500 Marcus Avenue
Lake Success, NY 11042
(516) 488-2822
(718) 343-3322

Agent for Service of Legal Process
The Board of Trustees has been designated as the agent for service of legal process. Process may be served at the Fund Office located at Local 282 Welfare Trust Fund, 2500 Marcus Avenue, Lake Success, N.Y. 11042. Service of legal process may be made on either a Fund Trustee or the Plan Administrator.

Source of Contributions and Method of Contribution Calculation
Benefits are provided from the Fund's assets that are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative charges. Some of the benefits are provided through insurance policies. The Fund's assets and reserves are held in custody and invested by the Board of Trustees. The Employer contributions are determined in accordance with the rates listed in the respective Collective

Bargaining Agreements. A complete list of the Employers and Employee organizations sponsoring the plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and Beneficiaries.

Collective Bargaining Agreements

The Fund is maintained pursuant to Collective Bargaining Agreements. Participants and beneficiaries can obtain a copy of any such agreement upon written request to the Fund Office.

Insurance and Administration

Hospital and PPO Comprehensive Medical and Surgical Benefits including Anesthesia Benefits are administered by **Anthem Blue Cross and Blue Shield**

Dental benefits are administered by **Sele-Dent, Inc.**

Prescription benefits are administered by **CVS Caremark.**

Group Life Insurance and Accidental Death and Dismemberment Insurance are insured and administered by **Standard Life Insurance Company of New York**

All other benefits are funded and administered by the Local 282 Welfare Trust Fund.

YOUR RIGHTS AND RESPONSIBILITIES UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Local 282 Welfare Trust 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 Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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 plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, provided you have first appealed the adverse benefit denial as required by the Plan, and within 365 days of your receipt of the adverse decision. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous. Any action against the Fund or the Trustees shall be brought in the Eastern District of New York.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Fund Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W.,

Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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