UPSTATE NEW YORK ENGINEERS

HEALTH FUND

SUMMARY PLAN DESCRIPTION

LOCAL UNIONS 17 & 158

of the

INTERNATIONAL UNION OF OPERATING ENGINEERS

OCTOBER 1, 2022

UPSTATE NEW YORK ENGINEERS HEALTH FUND

101 Intrepid Lane
P.O. Box 100 - Colvin Station
Syracuse, New York 13205-0100
Telephone: (315) 492-1796

April 1, 2022

Dear Participant:

We are pleased to provide you with this updated summary of your Plan of benefits (SPD) effective April 1, 2022. Since the purpose of the Upstate New York Engineers Health Fund is to provide you and your eligible family members with comprehensive health coverage, you should read all the Articles in this SPD carefully, so that you understand the ways in which the Plan may benefit you, as well as any exclusions and limitations on the receipt of benefits.

If you have any questions concerning this summary plan description, you should contact the Health Fund Office. The address and telephone number of the Upstate New York Engineers Health Fund are stated at the top of this page.

Sincerely,

THE BOARD OF TRUSTEES OF THE
UPSTATE NEW YORK ENGINEERS
HEALTH FUND

CAUTION

This booklet and the Fund Office are authorized sources of Plan information for you. The Trustees have not empowered anyone else to speak for them with regard to the Plan. No employer, employee, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority. No oral statements by Plan personnel or any other Plan representative may modify in any respect the written terms of the Plan.

COMMUNICATIONS

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

REQUIRED DOCUMENTATION

You must provide to the Fund Office any documents and information that it requests to process your claim or to determine your entitlement to benefits or participation in the Plan.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantees that any amount paid for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal and State income tax purposes, or that any other Federal or State tax treatment will apply to or will be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes and to notify the Fund Office if the Participant has reason to believe that any such payment is not so excludable.

FUND ADMINISTRATOR
Deborah M. Spaulding
101 Intrepid Lane
Syracuse, New York 13205

INVESTMENT CONSULTANT
SEI Investments
One Freedom Valley Drive
Oaks, PA 19456

ACCOUNTANT
Schultheis & Panettieri
450 Wireless Blvd.
Hauppauge, New York 11788

ACTUARIAL CONSULTANT
Bolton Partners, Northeast, Inc.
9000 Midlantic Drive, Suite 100
Mt. Laurel, NJ 08054

GENERAL COUNSEL
Slevin & Hart, P.C.
1625 Massachusetts Avenue, N.W.
Suite 450
Washington, D.C. 20036

EMPLOYER I.D. NO. 15-0582931

PLAN NO. 501

PLAN YEAR - April 1 through March 31

TYPE OF ADMINISTRATION: Self - administered, except as otherwise described in this SPD.

TYPE OF FUNDING: Self-insured, except as described in this SPD.

SOURCE OF CONTRIBUTIONS TO THE PLAN: Employers are required to contribute to the Fund pursuant to collective bargaining agreements or other written agreements with the Trustees.

COLLECTIVE BARGAINING AGREEMENT: This Plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the Fund Office and is available for examination by you at the Fund Office.

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

UPSTATE NEW YORK ENGINEERS HEALTH FUND

101 INTREPID LANE - P.O. BOX 100
SYRACUSE, NEW YORK 13205
TELEPHONE (315) 492-1796

UNION TRUSTEES

Terry Hogle
IUOE Local 158
District 545
5612 Business Avenue
Cicero, New York 13039

Daniel McGraw
Upstate NY Eng. Health Fund
101 Intrepid Lane - P.O. Box 100
Syracuse, New York 13205

William Fekete
IUOE Local 17
5959 Versailles Road
Lakeview, New York 14085

Gary Swain
IUOE Local 17
5959 Versailles Road
Lakeview, New York 14085

Michael Lyons
IUOE Local 158
27 Hannay Lane
Glenmont, New York 12077

EMPLOYER TRUSTEES

Earl R. Hall
Construction Employers Association of CNY, Inc.
6565 Ridings Road
Syracuse, New York 13206

Eugene Hallock III
Port of Albany
Albany, New York 12202

James Logan
Construction Employers Assoc.
2660 William Street
Cheektowaga, New York 14227

Nickolaus Osinski
Union Concrete and Construction Corp.
435 Meyer Rd.
West Seneca, NY 14224

Douglas May
Oakgrove Construction Co.
6900 Seneca Street
P.O. Box 103
Elma, New York 14059

Table of Contents

<u>Part A Introduction</u> 1

ARTICLE I – GENERAL MATTERS 1

About this Plan 1
About this Booklet 1
Plan Funding 1
Plan Administrator 2
How Benefits are Approved 2
Statement of ERISA Rights 2
Plan and Benefit Terminations and Changes 4
Special Enrollment Rights and Changes in Family Status 4
Fund Administration and Service of Legal Process 5
Payment 5
Confidentiality of Protected Health Information 5

<u>Part B Eligibility and Claims</u> 8

ARTICLE II – ELIGIBILITY 8

Eligibility – Active (non-retired) participants 8
Definitions 8
- Covered Employment 8
- Initial Eligibility for New Employees 8
- Eligibility for Newly Organized Groups 8
- Work Periods and Benefit Periods 9

Continuing Eligibility 9
Eligibility for Dependents 9
Termination of Eligibility 11
Maintaining Eligibility 11
Re-establishment of Eligibility 13
Additional Conditions 13
Withdrawal 13
Minimum contribution rate for benefits except the HRA benefits and the right of the Trustees to allocate the Fund contributions 14

ARTICLE III – HOW AND WHEN TO FILE A CLAIM 14

ARTICLE IV – COORDINATION OF BENEFITS 15

<u>Part C Continuation of Coverage</u> 17

ARTICLE V – COBRA CONTINUATION COVERAGE 17

Qualifying events for employees 17
Spouse eligibility for COBRA Coverage 18
Dependent Eligibility for COBRA Coverage 18
Notification to the Fund Office 19
Notification of COBRA Rights 19
Election of COBRA Coverage 19
Benefits provided under COBRA Coverage 20
Consequences of failing to elect or waive COBRA coverage 20
Duration and Termination of COBRA Coverage 20
How COBRA Coverage affects eligibility for other extended coverage 20

Cost and payment of COBRA Coverage 20
Additional Information about COBRA Coverage 21
Keep your Fund informed of address changes 21

ARTICLE VI – PARTICIPANT BUY-IN PLAN 21
Eligibility 21
Continuation of coverage rule 21
Benefits 21
Payment 22
Cost 22
Refunds 22
Exclusions 22

ARTICLE VII – WIDOWED SPOUSE BUY-IN PLAN 22
Requirements 22
Benefits 22
Payments 23

Part D Benefits 23
ARTICLE VIII – HOSPITAL BENEFITS 24

ARTICLE IX – MAJOR MEDICAL BENEFITS 27
General 27
Family out-of-pocket maximum 27
Charges related to a Mastectomy 28

ARTICLE X – PRESCRIPTION DRUG BENEFIT 28
General 28
Specialty Medications 28
Active participants and dependent eligibility 28
Widowed Spouse and Retiree-Buy-In coverage 28
Additional information 29

ARTICLE XI – OTHER BENEFITS 30
Doctors Office 30
Home health care 30
Mental and Nervous Disorder Benefit 31
Exclusions and Limitations 32
Other covered services 32
Self-Insured Death and Dismemberment Benefits 32
Pre-Retirement Surviving Spouse Death Benefit 32
Death and Dismemberment Benefit 32
Dental Benefits 34
Hearing Aid Benefit 37
Vision Benefit 37
Substance Use Coverage 38
COVID Vaccinations 39

ARTICLE XII – HEALTH REIMBURSEMENT ACCOUNT 40
General 40
Claim Procedures 40

Benefits 40
Forfeiture of Small Accounts 41
Administration 41

ARTICLE XIII – SECOND AND THIRD OPINION 41

ARTICLE XIV – EXCLUSIONS AND LIMITATIONS 41

Part E Retiree Buy-In Plans 45
ARTICLE XV – EARLY RETIREE BUY-IN PLAN 46
Requirements 46

ARTICLE XVI – NORMAL RETIREE BUY-IN PLAN 46
Requirements 46

ARTICLE XVII – DISABILITY RETIREE BUY-IN PLAN 47
Requirements 47

ARTICLE XVIII – MEDICARE SUPPLEMENT PLAN 48
Eligibility 48
Covered Benefits 48
Exclusions 48
Cost 49
Claims for Reimbursement 49
Termination 49

ARTICLE XIX – MEDICARE SUPPLEMENTAL BENEFIT 49

Part F General Matters 50
ARTICLE XX – CLAIMS INVOLVING THIRD PARTY LIABILITY 50
General 50
Rights to Subrogation and Reimbursement 50
Right of Future Subrogation and Reimbursement 52
Assignment of Claim 53

ARTICLE XXI – APPEAL PROCEDURE 54
Claim Procedure 54
Time Limit for Legal Action 60

ARTICLE XXII – PLAN INTERPRETATIONS, DETERMINATIONS, AMENDMENTS 60

ARTICLE XXIII – MISCELLANEOUS 61
Time Limit for Claims Submission 61
Recovery of Overpayment and Mistaken Payments 61
Cooperation 62
Payment on behalf of the Incompetent 62

PART A INTRODUCTION

ARTICLE I – GENERAL MATTERS

A. ABOUT THIS PLAN - The name of this Fund is the Upstate New York Engineers Health Fund. The Plan was created by Local Unions of the International Union of Operating Engineers (the "Participating Local Union"), and the employers who make contributions to the Plan (the "Contributing Employers"). The purpose of this Plan, which is a self -administered health plan, is to provide certain medical and other benefits to participants and their eligible dependents. You are considered to be a participant in this Plan if you work in Covered Employment for a Contributing Employer that has executed a collective bargaining agreement with the Participating Local Unions or a separate written agreement with the Plan, provided you have satisfied the eligibility requirements as set forth in Article II.

Grandfathered Plan Status

This group health plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan preserves certain basic health care coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what may cause a plan to change from grandfathered health plan status can be directed to the Fund Office (315) 492-1796. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/eba/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

B. ABOUT THIS BOOKLET - This Summary Plan Description is intended to describe the benefits you are entitled to as a participant in the Plan. Benefits include payments, which are made for the value of covered services rendered to you on your behalf. This SPD also describes the eligibility requirements for participation in the Plan, the limitations on benefits, the procedure for claiming your benefits, and other information, which you should know. Except as otherwise required by the context, use of masculine gender is intended to include the feminine.

The Summary Plan Description is effective April 1, 2022 and replaces all previous Plans, Booklets, Summary Plan Descriptions, and other material that describes the Plan. Thus, this Summary Plan Description fully replaces and takes precedence over all previous materials which describe this Plan's provisions.

This Summary Plan Description document functions as both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The terms contained herein constitute the terms of the Plan.

C. PLAN FUNDING - This Plan is a multi-union, multi-employer trust fund that provides various benefits to eligible participants employed by Contributing Employers. Many participants are represented by Participating Local Unions, but the Plan also covers other persons whose employer has entered into a separate written agreement with the Plan to provide coverage for them.

The Participating Local Unions are Local Unions #17 and #158, of the International Union of Operating Engineers.

You may obtain a complete list of all the Contributing Employers upon written request to the Fund Office, or you may examine the list at the Fund Office. You may also receive from the Fund Office, upon written request, information as to whether a particular employer is a Contributing Employer and, if the employer is, the employer's address.

Most Contributing Employers and the Participating Local Unions negotiate collective bargaining agreements pursuant to which the Plan is maintained. Other Contributing Employers enter into separate agreements with the Plan pursuant to which contributions are made for their employees. These agreements specify the amount the Contributing Employers will contribute to this Plan on behalf of the participants they employ. The Employer contributions are combined with the earnings from investments made by the Trustees on behalf of the Plan, and they are accumulated in a Trust Fund. Money in the Trust Fund is then used to provide benefits to participants and their eligible dependents, and to defray the reasonable administrative expenses incurred in operating this Plan.

D. PLAN ADMINISTRATOR - Your Plan is administered by a Board of Trustees, of which the Participating Local Unions and the Contributing Employers are equally represented. Thus, the Board as a whole is the Plan Administrator. As such, the Board is responsible for making decisions regarding, for example, the rules of eligibility, types of benefits offered, administrative policies, management of Plan assets, and interpretation of Plan provisions. If you have any questions about your Plan, you should contact the Board of Trustees by writing to: The Board of Trustees, Upstate New York Engineers Health Fund, 101 Intrepid Lane, PO Box 100, Syracuse, New York, 13205. The telephone number is: (315) 492-1796.

E. HOW BENEFITS ARE APPROVED - All benefits are provided directly by the Upstate New York Engineers Health Fund. This Plan is fully self-insured.

F. STATEMENT OF ERISA RIGHTS - As a participant in the Upstate New York Engineers Health 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 Benefit 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.

Continue Group Health Plan Coverage

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

If there is a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan, you should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note, pursuant to the Affordable Care Act, starting with the first plan year on or after January 1, 2014, with limited exception, health plans may not enforce pre-existing condition exclusions.)

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best 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 a suit in Federal Court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. In such a case, the court may require the Plan administrator to provide the material and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting the Plan's internal claims procedures. If it should happen that the 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 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 to be frivolous.

Assistance with Your Questions

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

The Department of Labor requires that this SPD contain the description of your ERISA rights set forth above. Its inclusion in this SPD is not offered, and should not be considered, as legal advice of any kind. For legal advice, you should consult with a licensed attorney.

G. PLAN AND BENEFIT TERMINATIONS AND CHANGES - Although it is not currently anticipated that the Trustees will terminate the Plan, the Board of Trustees reserves the right to terminate it at any point in the future. The continuation of this Plan is also contingent upon the continuation of employer contributions to the Plan.

If the Plan is terminated for any reason, the assets remaining in the Plan will be utilized to pay necessary administrative costs and remaining benefits. Until such assets are so expended, no further benefits would be provided by the Plan. Upon termination of this Plan, participants and beneficiaries would have no further rights under the Plan.

The Board of Trustees also reserves the right to amend, modify, or terminate (i) the Plan (ii) the types and amounts of benefits provided under the Plan, including retiree benefits, and/or (iii) the eligibility, even if such extended eligibility has already been accumulated. Furthermore, the benefits provided by this Plan are subject to modification or termination by the Trustees, even if such action is not financially necessary. Thus, the continuation of benefits for all participants and beneficiaries, including retirees, and the eligibility rules for benefits under this Plan are subject to modification and revision by the Trustees.

No participant, beneficiary, or eligible dependent has a vested right or contractual interest in the benefits provided. The provisions of benefits to individuals under this Plan will be reviewed periodically by the Trustees.

H. SPECIAL ENROLLMENT RIGHTS AND CHANGES IN FAMILY STATUS

1. **Coverage under this Plan is automatic upon your attaining eligibility. However, by law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage:** For example, if you decline enrollment for your dependents (including your spouse) because of other health coverage and that health care coverage ends, your eligible dependents have a right to enroll in coverage retroactive to the date the other coverage terminated, provided you properly enroll them within 30 days of losing such coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement with you for adoption, you may be able to enroll your new dependents, provided that you properly enroll them within 30 days after the marriage, birth, adoption or placement with you for adoption.

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must properly enroll in Fund within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must properly enroll in Fund coverage within 60 days after you (or your dependents) are determined to be eligible for such assistance.

2. **Change in family status**: Please note that it is important that you give prompt written notice to the Fund Office of <u>any</u> changes in your family or beneficiary status, such as marriage, separation, divorce, birth of a child, or adoption.

I. FUND ADMINISTRATION AND SERVICE OF LEGAL PROCESS - The Trustees have designated Deborah M. Spaulding as Fund Director. As Fund Director, she is responsible for carrying out the Trustees' decision and for overseeing the daily operation of the Fund and the Fund Office.

In addition, the Trustees have designated the Fund Director as the agent of service of legal process. The address at which process may be served on the Fund Director is as follows: Deborah M. Spaulding, Upstate New York Engineers Health Fund, 101 Intrepid Lane, P.O. Box 100, Syracuse, New York 13205. The telephone number is: (315) 492-1796.

Service of legal process upon Deborah M. Spaulding will be deemed to be service upon the Board of Trustees. However, service of legal process may also be made upon any Trustee.

J. PAYMENT - Benefits will be paid directly to the participant unless payment has been assigned to the person or organization that provided the service.

K. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION - A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Personal Health Information ("PHI") effective April 14, 2003. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which is available upon request from the Plan's Privacy Official, Deborah Reinhardt.

This Plan, and the Plan Sponsor (the Board of Trustees of the Upstate New York Engineers Health Fund), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual, but are not limited to the following:

1. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participants claim);

2. coordination of benefits;

3. adjudication of health benefit claims (including appeals and other payment disputes);

4. subrogation of health benefit claims;

5. COBRA contributions;

6. risk adjustment amounts due based on enrollee health status and demographic characteristics;

7. billing, collection activities and related health care data processing;

8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

9. obtaining payment under contract for reinsurance (including stop-loss and excess of loss insurance);

10. medical necessity reviews or reviews or appropriateness of care or justification charges;

11. utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;

12. disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: names and address, date of birth, Social Security number, payment history, account number and the name and address of the provider and/or health plan); and

13. reimbursement to the plan.

"Health Care Operations" include, but are not limited to, the following activities:

1. quality assessment;

2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contracting health care providers and patients with information about treatment alternatives and related functions;

3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

4. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development and improvement of payment methods or coverage policies;

6. business management and general administrative activities of the Plan, including but not limited to management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

7. resolution of internal grievances; and

8. due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of a merger, will become a covered entity.

Only the employees of the Upstate New York Engineers Health Fund who assist in the Plan's administration, the Fund's business associates and the Board of Trustees of the Upstate New York Engineers Health Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for Plan administration functions. The Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose your PHI for impermissible purposes.

HIPAA allows the Fund to disclose your PHI to the Plan Sponsor only upon receipt of a Certificate by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions in connections with any other benefit or employee benefit plan of the Plan Sponsor; (d) report to this Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for of which it becomes aware; (e) make available PHI; (f) make available PHI for amendment and incorporate any amendments to PHI; (g) make available the information required to provide an accounting of disclosures; (h) make its internal practices, books and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Service for purposes of determining compliance by this Plan; (i) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (j) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Deborah Rienhardt, Health Fund Supervisor at (315) 492-1796 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

In addition, the Plan Sponsor will:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

2. ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

3. ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

4. report to Plan any security incident of which it becomes aware concerning electronic protected health information.

PART B ELIGIBILITY AND CLAIMS

ARTICLE II – ELIGIBILITY

A. ELIGIBLITY – ACTIVE (NON–RETIRED) PARTICIPANTS - This Article describes how to become and remain eligible for the benefits offered by the Plan.

For the purposes of this SPD, the term "you" generally refers to people who are or who may become eligible for benefits from this Plan due to their employment, and not as dependents.

B. DEFINITIONS - For the purpose of this Article, the following terms have the following definitions.

1. **COVERED EMPLOYMENT** – "Covered Employment" means work for which your employer is required to contribute on your behalf to the Upstate New York Engineers Health Fund, either because of its collective bargaining agreement with a Participating Local Union or because it has a separate agreement with the Board of Trustees.

2. **INITIAL ELIGIBILITY FOR NEW EMPLOYEES OR EMPLOYEES WHO HAVE REENTERED COVERED EMPLOYMENT WITHIN THREE YEARS OF TERMINATION** – An individual who becomes employed for the first time in Covered Employment or a participant who was not covered under the Fund's medical plan for 3 consecutive years prior to becoming reemployed in Covered Employment will become eligible for benefits under this Plan on the first day of the month immediately following the completion of 300 hours in Covered Employment within the preceding four month period.

3. **ELIGIBILITY FOR NEWLY ORGANIZED GROUPS** – Employees in newly organized groups may become participants in the Fund on either the date the organization occurs or on the day following the day in which the group's current health coverage expires, so long as the minimum hours in Covered Employment are

met. For more information on the minimum hours requirement for newly organized groups, please contact the Fund Office.

4. **WORK AND BENEFIT PERIODS –** The number of hours in Covered Employment contributed on during Work Periods, by a Contributing Employer, will determine the Benefit Period(s) in which you are eligible for benefits from this Plan.

WORK PERIODS	BENEFIT PERIODS
April 1 through July 31	August 1 through January 31
August 1 through November 30	December 1 through May 31
December 1 through March 31	April 1 through September 30

C. CONTINUING ELIGIBLITY - Once your eligibility begins you will remain eligible for benefits from this Plan for subsequent Benefit Periods as long as you meet the following requirements:

(i) You are working in Covered Employment or if you are not working in Covered Employment, you are available for work in Covered Employment; and

(ii) Contributions are received by the Fund on your behalf for (1) at least 300 hours in the immediate preceding Work Period; or (2) at least 600 hours in the two immediate preceding Work Periods; or (3) at least 900 hours in the three immediate preceding Work Periods.

For the purpose of being considered "available for work in Covered Employment," you must be included in the Union's out-of-work list if your Local Union has an out-of-work list. You are considered not available for Covered Employment if the Union has advised the Fund Office that you have not been available for Covered Employment or you are engaged in full time, non-Covered Employment, unless you prove to the satisfaction of the Fund's Board of Trustees, that such non-Covered Employment is temporary employment intended to provide income during periods in which you are unable to find work in Covered Employment. This is not an exhaustive list. The Fund will determine whether you are available for work in Covered Employment based on all the relevant facts and circumstances.

NOTE: Refer to Section G of this Article for additional details regarding continuing eligibility during a period of disability or medical leave, or qualified military service.

D. ELIGIBILITY FOR DEPENDENTS - If you are eligible for benefits from this Plan, then your eligible dependents may also be eligible for benefits from this Plan. Under the Plan, you may enroll the following eligible dependents.

1. your legal spouse;

2. your children (natural, step and adopted children) who have not attained the age of 26; and

3. your lawfully adopted child (who meets the age requirement as stated in paragraph #2 above) includes: a child lawfully placed with you for adoption by you, or a foster child placed with you by an authorized placement agency. Such child may qualify as your dependent by submitting proper documentation to the Fund that demonstrates the child's eligibility dependency.

Coverage will continue past the age of 25 for your unmarried, permanently and totally disabled children who reside with you because they are unable to support themselves due to mental or physical disability, provided they are covered and incapacitated at the time they attain the age of 26. They will remain eligible for benefits so long as their condition remains the same, you continue to be covered under the Plan, they continue to reside with you, and they do not qualify for, or are insured under another health insurance plan, including but not limited to Medicare or Medicaid to the extent permitted under applicable law

The Fund will also provide benefits pursuant to the terms of a "Qualified Medical Child Support Order" as defined in Section 609 of ERISA as the result of any domestic relations order.

Your newborn dependent child's eligibility begins at birth provided you enroll the child in coverage within 30 days of birth. If you are adding a dependent you must notify the Fund Office at once of this change. Throughout this SPD, children qualifying for coverage are referred to as dependent children unless the context indicates otherwise.

If both you and your spouse are eligible for benefits under the Plan, both of you may cover your children as dependents under the Plan, but in no event will the payments exceed 100% of the covered amount.

If you wish to obtain coverage for your grandchildren, then you must submit documentation to the Fund Office establishing one of the following in order for such grandchildren to be considered eligible dependents under the Plan: that you have legally adopted the grandchildren, that you are the legal guardian of the grandchildren or that you have been awarded custody of the grandchildren. In such event the court order establishing the adoption, guardianship or custodianship must be submitted to the Fund Office.

NOTE: TO BECOME OR REMAIN ELIGIBLE FOR BENEFITS AS DEPENDENTS UNDER THIS PLAN, THE FOLLOWING PROOF, WHEN APPLICABLE, MUST BE SUBMITTED TO THE FUND OFFICE UPON REQUEST:

- Your marriage certificate must be submitted in order to prove you are currently legally married to your spouse. Common law spouses are not legally recognized in the State of New York, and are not considered eligible dependents under this Plan.

- To cover your children, you must submit a copy of each child's birth certificate or equivalent documentation, showing you as the parent, to the Fund Office. The Fund Office needs this information to confirm your child's age as well as whether your child qualifies as a dependent under the Plan.

- Proof of disability must be submitted to the Board of Trustees no later than 31 days after the attainment of age 25 for the child that you claim is eligible for coverage beyond age 25. Additionally, proof of the continued existence of such child's disability must be provided periodically, as requested by the Board of Trustees.

E. TERMINATION OF ELIGIBILITY -Your eligibility for benefits will end on the last day of a Benefit Period if you fail to meet the continuing eligibility rules described in subsection (C) or if you fail to provide documentation required by the Fund to prove your entitlement to continued eligibility. However, if your coverage ends because you are no longer available for work in Covered Employment, your coverage ends on the date on which you are no longer available for Covered Employment, regardless of the number of hours you worked during the corresponding Work Period(s).

If you work for a Contributing Employer who is delinquent in making the required contributions to the Plan, those contributions may be collected by the New York State Department of Labor and paid directly to you. Because those contributions belong to the Plan, your eligibility for benefits will be terminated if you fail to promptly remit to the Plan the full amount that you received from the New York State Department of Labor.

If your spouse is eligible as a dependent and you become divorced, or your marriage is annulled or a written separation agreement is in place between you and your spouse, then your spouse's eligibility will automatically terminate on the date this occurs. However, your spouse may elect COBRA continuation coverage pursuant to Article V.

Article V describes how your dependents may qualify for COBRA continuation coverage, after their eligibility for benefits expires.

If you work for a Contributing Employer that is no longer required to make contributions to this Plan on your behalf, then your eligibility and the eligibility of your eligible dependents, for benefits from this Plan will be terminated as of the first day of the month following the month in which your employer is no longer required to make contributions to the Plan.

Also, your eligibility and the eligibility of your eligible dependents will terminate on the first day in which you become employed in non-covered employment. Non-covered employment is employment in which your employer is not required to remit contributions on your behalf. **NOTE: You must immediately notify the Fund Office that you are employed in non-covered employment.**

F. MAINTAINING ELIGIBILITY

1. DURING A PERIOD OF DISABILITY

Up to a maximum of 300 hours will be credited towards the eligibility of an active participant who is disabled by sickness or accident, provided they are eligible participants in the Health Plan. Proof of disability must be submitted to the Fund Office. Forms for proof of disability may be obtained from either your Local Union or the Fund Office.

2. UNDER THE FAMILY AND MEDICAL LEAVE ACT

Under Federal law, you may be eligible for up to twelve weeks of unpaid leave from your employment for any of the following reasons:

(a) You need to care for your newly-born or adopted child;

(b) You need to care for your spouse, child or parent who has a serious health problem; or

(c) You have a serious health problem, which prevents you from performing your job.

(d) A qualifying exigency that arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes a) notification of military deployment within 7 days of the deployment date; b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; d) making financial and legal arrangements; e) attending counseling sessions; f) up to 5 days of rest and recuperation; g) attendance at post-deployment activities.

You may also be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in the military service.

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

3. QUALIFIED MILITARY SERVICE

If you leave employment for full-time Qualified Military Service, as defined by Federal Law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage, subject to the provisions of the Plan, may last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter Qualified Military Service and are discharged earlier and fail to make a timely application for reemployment upon discharge.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty (30) days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to pay a monthly premium to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two percent (2%) administrative charge.

4. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize Qualified Medical Child Support Orders ("QMCSO"). A QMCSO is a court decree under which a court order requires the Plan to cover a child that is otherwise not eligible for coverage. Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Administrator. Upon receipt of the medical child support order, the Plan administrator will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant in the Fund and will receive copies of summary plan

descriptions, summary annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

G. RE-ESTABLISHMENT OF ELIGIBILITY - If your eligibility for benefits is terminated because of your failure to work the necessary hours in Covered Employment for a Contributing Employer, then your benefits under this Plan will be reinstated on the first day of the month after contributions have been received by the Fund on your behalf for at least 300 hours during no more than a four consecutive month period.

Retired employees over the age of 65 receiving benefits from the Upstate New York Engineers Pension Fund who return to Covered Employment will be subject to this Plan's eligibility terms, in the same manner as other active employees.

H. ADDITIONAL CONDITIONS - The following additional conditions apply:

1. This Fund has become party to Reciprocity Agreements between different Welfare Plans sponsored by Local Unions that are not signatory to agreements requiring contributions to this Fund. These agreements were established in order to preserve eligibility and provide benefits for a participant of this Plan when the participant works outside the jurisdiction of the Plan. However, when the employer contribution rate reciprocated to this Fund is less than the employer contribution rate required to be remitted to this Fund as determined by the Trustees for work within the jurisdiction of the signatory Unions, then participants on whose behalf the lesser rate of employer contributions are received pursuant to Reciprocal Agreements shall be entitled to eligibility on a pro rata basis. For questions regarding which funds the Fund has reciprocity agreements with, please contact the Fund Office.

2. The Trustees may in their sole discretion, reduce or increase the hours requirements for eligibility because of excessive unemployment or poor economic conditions in the construction industry.

3. Each participant must file an enrollment card with the Fund Office in order to be eligible for benefits from this Plan, and in order to receive annual statements and other information from the Plan. If there is a change of information on the enrollment card, then it is important that the Fund Office be notified.

   New enrollment cards are available at your Local Union or at the Fund Office. This is the best and surest method of notification. The enrollment card with the latest date is the one recognized by the Plan.

I. WITHDRAWAL

1. Eligibility for any and all health benefits (for active participants, retirees and dependents) from the Fund shall terminate on the first day of the month following the month during which the employer no longer has an obligation to contribute to the Fund because it has entered into a collective bargaining agreement terminating its obligation to the Fund (hereafter a "withdrawal").

2. The Fund will not enter into any reciprocal or other agreement with any other fund that has participants, some of whom previously were participants in the Fund and who lost eligibility as the result of a withdrawal.

3. Participants in the Fund who are members of an I.U.O.E. Local Union that withdraws from the Upstate New York Engineers Health Fund shall not be entitled to any benefits from the Fund (including, but not limited to, balances in Health Reimbursement accounts) immediately upon that Local Union's withdrawal from the Fund.

4. The Fund will not provide any assistance, administratively, operationally, functionally, or otherwise to any entity providing benefits to members of any I.U.O.E. Local Union that has withdrawn from the Upstate New York Engineers Health Fund.

J. MINIMUM CONTRIBUTION RATE FOR BENEFITS EXCEPT THE HRA BENEFITS AND THE RIGHT OF THE TRUSTEES TO ALLOCATE THE FUND CONTRIBUTIONS -The benefits provided by the Fund (HRA benefits and non-HRA benefits), including to retirees, are not vested. The Trustees may terminate an employer's participation in the Fund if the bargaining parties fail to adopt a collective bargaining agreement with a contribution rate that is sufficient to maintain the Fund's plan of benefits.

ARTICLE III – HOW AND WHEN TO FILE A CLAIM

Present your Aetna identification card to your service provider. The identification card provides the address to which the claim form may be sent via mail or electronically. All Medical and Medicare Supplement claims must be forwarded to the address shown on your identification card.

If you have other coverage in addition to Fund coverage, the Fund must have an itemized bill with a statement from the other insurance provider of coverage showing their payment or rejection on all charges.

All claims for payments of expenses and/or benefits covered by this Plan must be submitted to the Fund Office within (12) months after the later of (i) the date of service, or the (ii) earliest date of entitlement to the benefits. Claims submitted after this deadline will be denied as untimely.

For dental claims, your benefits are administered through a contract with Delta Dental. To receive dental benefits, present your Delta Dental I.D. card to your network dentist at the time services are provided. Your network dentist will make arrangements to receive payment from Delta Dental directly. For non-participating dentists, you will pay for the services as required by your dentist. You or your non-participating dentist should submit any inquiries about your dental benefits to Delta Dental directly at the following address:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055
Customer Service: (800) 932-0783
Website: deltadentalins.com

For more information about your dental benefits, see the "OTHER BENEFITS" section of this SPD.

ARTICLE IV – COORDINATION OF BENEFITS

Quite frequently, working parents are covered under more than one "health care plan." Thus, in some instances, the combined benefits received under both plans could exceed the medical bill. Therefore, if both parents are covered under this Plan, as well as another plan providing medical benefits, then these Coordination of Benefits rules apply. Since the purpose of a benefit program is to cover medical expenses and not to make a "profit" from being sick, the rules determine the portion of your expenses that will be paid by each plan. The rules determine how the benefits payable under one of the two plans in such case will be reduced so that the total benefits payable under all plans will not exceed the "allowable expenses" incurred during any calendar year.

Under the Coordination of Benefits rules, one plan is determined to be the "Primary Plan." That plan pays its benefits first, as if there were no coordination of Benefit rule. The other plan, the "Secondary Plan" determines its benefits only after the Primary Plan has made a determination as to what it will pay. "Allowable expenses" means any necessary, reasonable and customary items of expense for medical care or treatment covered under at least one of the plans. A "Health Care Plan" is any program providing health care coverage on an insured basis or uninsured basis. This includes another individual or group welfare plan, Blue Cross/Blue Shield, Labor Management Trust Funds, and any prepayment arrangements, Group or Blanket Insurance and any coverage under Governmental Programs (except Medicaid and No-Fault Auto Insurance).

If the other plan, which may be liable for benefits, does not contain a Coordination of Benefits provision, this Plan will be the Secondary Plan. If the other plan does not contain such provisions, this Plan will be the Primary Plan if the person incurring the expenses is covered by this Plan as an employee. If the person incurring the expense is covered by this Plan as a dependent, this Plan will be the Secondary Plan if the other plan covers such person as an employee regardless of the coordination of benefits provision or other terms of the dependent's other plan.

If your children are eligible for coverage under both this Plan and the plan provided by the other parent's Employer, then this Plan will be the Primary Plan if your birthday falls earlier in the calendar year than the other parent's birthday. If you happen to have the same birthday, this Plan will be the Primary Plan if it has covered you longer than the other parent's plan.

If the expenses are for a child whose parents are divorced or separated, the plan covering the parent with custody is primary. If the parent with the custody remarries, the order of payment is as follows:

- Natural parent with whom the child resides;
- Step-parent with whom the child resides;
- Natural parent not having custody of the child.

If the divorce decree makes one parent liable for the expenses of the child's medical care, then the plan covering that parent will be the Primary Plan regardless of these rules.

If the other Health Care Plan is a No-Fault Auto Insurance Policy, this Plan will be the Secondary Plan. If the other Health Care Plan is Medicaid, this plan will be the Primary Plan. If for some reason, the proper Coordination of Benefits cannot be determined under these rules described above, the plan that covered the patient for the longest time is the Primary Plan. The other plan is the Secondary Plan.

It is your obligation to notify the Fund if you, or any of your eligible dependents are covered by another health care plan. If you fail to do so, any amount by which this Plan overpays benefits will be recovered from you and or your dependent, either directly or through a reduction in future benefits.

Without your permission, and without notice to you, this Plan may release to, or obtain from, any person, company, or organization, information which this Plan believes is necessary to carry out the purpose of this Article to the maximum extent permitted by law. This Plan will not be legally responsible to anyone for releasing or obtaining information. You must furnish to this Plan, any information requested. If you do not do so, the Plan reserves the right to deny benefits until you do.

IMPORTANT

IF THE PARTICIPANT AND THE UNEMPLOYED SPOUSE ARE PARTICIPANTS IN ANY OTHER PRIVATE HEALTH CARE PLAN, EITHER AS A GROUP OR INDIVIDUAL, ALL CLAIMS MUST BE SUBMITTED TO THE OTHER PLAN FIRST. THE UPSTATE NEW YORK ENGINEERS HEALTH FUND WILL PAY THE BALANCES BASED UPON PLAN PROVISIONS.

COORDINATION OF BENEFITS WITH MEDICARE

When you become eligible for Medicare, you will be considered to be insured under Part A and Part B of Medicare. This is regardless of whether or not you have registered for Part A or enrolled in Part B.

We suggest, therefore, that at least 3 months before you reach age 65, or 3 months before you receive your 24th Social Security disability payment, you contact your local Social Security office. This is necessary so that, as soon as you are eligible, you are adequately covered by Medicare, which includes both Part A for hospital coverage and Part B for medical expenses.

If Medicare is your primary plan and there are covered charges remaining unpaid (that is, after Medicare has paid or would have paid), you will be reimbursed by the Plan up to the maximum amount approved by Medicare. However, the total amount received from Medicare and the Plan will never be more than 100% of your “Allowable Expenses.” “Allowable Expenses” are any necessary and reasonable expenses for medical services, treatment, or supplies covered under this Plan.

In general, if you are covered by this Plan as an active employee, and this Plan is receiving employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary to the extent you are also entitled to coverage under Medicare. However, notwithstanding this general rule, this Plan will not be primary for any individuals (including eligible active employees) who are age 65 and over and who have end stage renal disease and are, or would upon application be, entitled to benefits under 42 United States Code Section 426-1.

For eligible individuals under age 65 who are entitled to Medicare solely because of end-stage renal disease, this Plan will be primary and Medicare will be secondary for 30 months. Thereafter, Medicare will be primary.

It must be stressed that if you are a covered person nearing age 65 you may suffer a loss of benefits if you fail to enroll in Medicare because, even if you don’t enroll in Medicare, claims will be paid as if you had.

PART C CONTINUATION OF COVERAGE

This section contains three (3) different programs that allow for the continuation of health care coverage if a participant loses eligibility for benefits or if a participant dies leaving surviving dependents. The three (3) plans are as follows:

1. COBRA Continuation Coverage

2. Participant Buy-In Plan (Voluntary Buy-In Insurance Plan)

3. Widowed Spouse Buy-In Plan

Please note that there may be other coverage options for you and your family if you lose coverage. For example, starting in 2014, you are able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: healthbenefitexchange.ny.gov.

ARTICLE V – COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. The Fund's COBRA Continuation Coverage is administered by the Fund Office. Unlike the self-pay coverage described in Article VI of this booklet, your spouse and your dependent children may elect COBRA Continuation Coverage even if you do not.

There are two parts to your coverage under the Plan: (1) your health benefits; and (2) your health reimbursement account benefits. You, your spouse, and your dependents may elect COBRA continuation coverage for the health benefits only or for both the health benefits and the health reimbursement account (HRA) benefits.

A. QUALIFYING EVENTS FOR EMPLOYEES - For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of health coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan. Including but not limited to a reduction in hours worked, including a strike, walkout or layoff. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your health reimbursement account (HRA) as long as your HRA has not been forfeited as discussed in Article XII of this booklet. You will continue to have access to the balance in the Fund's HRA so long as the account balance is sufficient to cover your claims. In fact, your HRA balance can be used to pay the required COBRA premiums to maintain your health coverage.

B. SPOUSE ELIGIBILITY FOR COBRA COVERAGE - Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.

2. Your spouse's loss of coverage under the Plan due to your voluntary or involuntary termination of your employment (except gross misconduct) or because you no longer meet the eligibility requirements of the Plan including but not limited to a reduction in hours worked including a strike, walkout or layoff.

3. Divorce or judicial order of legal separation, or a written separation agreement is in place between you and your spouse.

4. Your enrollment in Part A or Part B of Medicare.

If you die or lose coverage as a result of the termination of employment or reduction in hours, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums solely to continue to receive reimbursements from your balance in the Fund's HRA as long as your HRA balance has not been forfeited as described in Article XII of this booklet. Your spouse will continue to have access to your HRA balance so long as the account balance is sufficient to cover the claims.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or legal separation, to continue to have access to your HRA balance, your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

C. DEPENDENT ELIGIBILITY FOR COBRA COVERAGE - Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.

2. Your dependent child's loss of health coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan. Including but not limited to a reduction in hours worked, including a strike, walkout or layoff.

3. Your enrollment in Part A or Part B of Medicare.

4. The child ceases to qualify as an "eligible dependent" as described in Article II.

If you die or lose coverage as a result of termination of employment or reduction in hours, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums solely to continue to receive reimbursements from your balance in the Fund's HRA as long as your HRA has not been forfeited as discussed in Article XII of this booklet. Your dependent child will continue to have access to your HRA so long as the account balance is sufficient to cover the claims.

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

D. NOTIFICATION TO THE FUND OFFICE -Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer with an obligation to contribute to the Fund, for purpose of administering COBRA, you will be considered to have terminated employment when your coverage under the Plan terminates, regardless of whether any of your employers have notified the Fund. However, if you lose eligibility because you are not available for Covered Employment as described on page 9, in order to be eligible to elect to continue your coverage under COBRA, you must provide the Fund Office with a written notice within 60 days of the date on which the event that deems you no longer available for Covered Employment occurred. For example, assume you are covered by the Fund for the period December 1, 2015 through May 31, 2016 because contributions were received by the Fund on your behalf for 350 hours during August 1, 2015 through November 30, 2015. You continue to work in Covered Employment from December 1, 2015 through December 31, 2015, at which time you are laid off. On January 15, 2016 you accept full-time work in non-covered employment. Your coverage with the Fund ends on January 15, 2016 because you are no longer considered to be available for Covered Employment. You must notify the Fund Office of your work in non-covered employment no later than March 15, 2016 to be eligible to elect to continue your coverage under COBRA. If you fail to do so, you will lose your right to elect to continue your coverage under COBRA.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, if a written separation agreement is in place between you and your spouse, a child's loss of status as an eligible dependent, the birth or adoption of a dependent or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund Office in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

E. NOTIFICATION OF COBRA RIGHTS - After the Fund receives notice of the occurrence of one of the qualifying events, the Fund will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send materials necessary to make the proper election. In general, the Fund will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has been determined that your regular group health coverage has been terminated.

F. ELECTION OF COBRA COVERAGE -The employee, spouse and dependent children each have independent election rights with respect to COBRA. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the

competed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation will begin on the date of delivery.

G. BENEFITS PROVIDED UNDER COBRA COVERAGE -The benefits an eligible individual is allowed to elect to receive under COBRA include all health and dental benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits) or disability benefits, accidental death and dismemberment benefits, surviving spouse death benefits, vision benefits or other non-health benefits are included.

H. CONSEQUENCES OF FAILING TO ELECT OR WAIVE COBRA CONTINUATION COVERAGE - In considering whether to elect continuation coverage you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. For example, you may not be able to enroll in a market place plan until its next open enrollment period if you do not enroll in such a plan within the time period required by law following the termination of your coverage with the Fund.

I. DURATION AND TERMINATION OF COBRA COVERAGE - If your COBRA eligibility is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day your coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations COBRA coverage is available for 36 months from the date your coverage ends. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the employer).

4. The individual enrolls in Part A or Part B of Medicare.

5. Circumstances are such that the individual’s participation could be cancelled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

J. HOW COBRA COVERAGE AFFECTS ELIGIBILITY FOR OTHER EXTENDED COVERAGE - Anyone who becomes eligible for COBRA continuation coverage, but who is also eligible for extended coverage under the “Continuing Eligibility” provisions of Article II, will not begin his or her period of COBRA coverage until after exhausting the other extended coverage available to that individual under the plan.

K. COST AND PAYMENT OF COBRA COVERAGE -Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The first payment must be made within 45 days of the date written

election of coverage is made. After the first payment is made, future payments must be made within thirty (30) days after the first day of the month.

The monthly premium will be based on the average cost that the Plan incurs annually per participant plus a two percent administrative charge. The additional 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge, based on one and one-half times the annual per participant cost incurred by the plan. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants described in Article VI.

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

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa, (Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website).

M. KEEP YOUR FUND INFORMED OF ADDRESS CHANGES - In order to protect your family's rights, you should keep the Fund Office informed of any changes in the address of your dependents. You should also keep a copy, for your records, of any notices you send to the Fund Office.

ARTICLE VI – PARTICIPANT BUY-IN PLAN (Voluntary Buy-In Plan)

The Participant Buy-In Plan is provided to offer limited health coverage for participants and eligible dependents. The Participant Buy-In Plan is offered for the following purpose:

To assist active participants who lose their regular coverage due to a reduction in their hours of Covered Employment. Any active participant can lose eligibility for regular coverage on January 31, May 31 or September 30.

ELIGIBILITY - Active participants who lose their regular coverage because they fail to work enough hours in Covered Employment during a Work Period may purchase this coverage for a period of six (6) consecutive months beginning on the first day the participant becomes ineligible for regular coverage. However, the coverage is not available to the participant and any dependents that are enrolled in or eligible for Medicare, to the extent permitted under applicable law. Coverage will also terminate before the end of the six (6) month period if the participant or dependent becomes eligible for Medicare, to the extent permitted under applicable law.

CONTINUATION OF COVERAGE RULE - You must purchase this coverage on or before the first day you become eligible for this coverage. If you choose not to purchase this coverage at the initial offering, you will be disqualified from purchasing this coverage until you lose your regular coverage again.

BENEFITS - The medical benefits of the Participant Buy-In Plan are the same as the regular coverage provided by the Plan, excluding dental, vision, hearing aid benefits and death benefits. Please refer to Part D of this booklet. The Coordination of Benefit rules will apply.

PAYMENT - Payment for this coverage MUST be postmarked on or before the first day of the month in which coverage is being purchased. Premiums must be submitted in the form of a personal check or a money order only. Premiums may also be paid from your Health Reimbursement Account balance (HRA) so long as your account balance is sufficient to cover the premium. Any late payments will be returned and you will become disqualified from participating in this Plan until you lose your regular coverage again.

COST - The monthly cost of the Participant Buy-In Plan is set by the Board of Trustees on an annual basis. The cost is vastly reduced when compared to the cost of a commercial health insurance policy. For those participants interested in this coverage, please contact the Fund Office for further information.

REFUNDS - In the event a participant becomes eligible for regular coverage during the six (6) consecutive month Buy-In period, a refund will be issued for any month(s) you purchased this coverage in which you were eligible for regular coverage.

EXCLUSIONS - Since the Participant Buy-In Plan was provided to offer limited coverage for active, non-retired eligible participants and eligible dependents who lost their regular coverage due to a reduction in hours worked in Covered Employment, participants and dependents are excluded from participating in the Participant Buy-In Plan if the participant is not available for Covered Employment at the time this Plan is offered, or is not available for Covered Employment at any time during the six (6) consecutive month Buy-In period. See Part B, Section C for how a person is considered to not be available for Covered Employment

ARTICLE VII – WIDOWED SPOUSE BUY-IN PLAN

REQUIREMENTS

1. (a) The deceased participant must have been a participant in the Fund with a minimum of 4,000 contributed hours during the (5) Employment Years included in the Computation Period in which the number of contributed hours for the participant was greatest. For purposes of this determination, an "Employment Year" is the twelve (12) month period ending on the last day of the month during which the participant died. The "Computation Period" is the seven (7) Employment Years immediately preceding the participant's death.

   (b) The participant must have accrued at least fifteen (15) years of Vested Service with the Pension Fund; and

2. The widowed spouse must have been married to the deceased participant at least one year prior to the death or one year prior to the effective date of his pension with the Upstate New York Engineers Pension Fund; and

3. The widowed spouse must not have other health insurance coverage (either individual or group insurance or be eligible for or enrolled in Medicare).

BENEFITS - The coverage for the Widowed Spouse Buy-In Plan is the same coverage as the Early and Normal Retiree Health Buy-In coverage as described in Part E "RETIREE BUY-IN PLANS."

PAYMENTS - Payment of premium for this coverage must be deducted from the monthly pension benefits, if the widow is receiving benefits from the Pension Fund.

The widowed spouse and the dependent children may participate in the Widowed Spouse Buy-In Plan until the widow becomes eligible for Medicare (at which time the Medicare Supplement Plan may be offered) or the widowed spouse remarries. If the coverage of the widowed spouse terminates for any reason, the coverage for the dependent children will also terminate.

In the event a widowed spouse wishes to terminate coverage under this Buy-In Plan, he or she must write to the Upstate New York Engineers Pension Plan so indicating. Termination from this Buy-In Plan is permanent. Re-entry into this Buy-In Plan is prohibited.

PART D BENEFITS

Articles VIII through XI describe the various medical benefits offered by the Fund. Many of the service providers, including hospitals, outpatient facilities, home health care programs, durable medical equipment providers, and other medical specialty providers are participants of the Plan's Preferred Provider Organization (PPO).

Aetna is the Plan's PPO provider. Aetna has established contractual agreements with many of the medical service providers in upstate New York. These contractual agreements may provide substantial reductions in charges and fees charged by the service provider. This in turn saves the Fund money and also may reduce your out-of-pocket costs.

Each eligible participant is furnished with an identification card. You are required to present your identification card to your service providers or inform your service providers that the Health Fund participates in the Aetna network. You are not required to use the service providers in the Aetna network however, doing so will save you money. If you wish to inquire about the service providers that participate or wish to know if your service provider participates in the Aetna network, please call the Fund Office.

Additionally, Aetna provides managed care services to eligible participants. When you use a service provider for non-emergency hospital admissions that are scheduled in advance, or use an outpatient facility, or require the use of durable medical equipment, or home health care, or are planning a surgical procedure in a service provider's office, you or your service provider is required to call Aetna. The phone number is **1-833-976-1877.** Calling Aetna, for managed care services, allows the Fund Office to assess certain medical procedures that are scheduled in advance and to confirm that the care you are receiving is in compliance with the benefits provided by the Plan, that the charges for services are reasonable and customary, and allows Aetna, in certain cases, to negotiate a reduction in fees and costs, which can save the Plan money and reduce your out-of-pocket costs.

The Aetna network covers the upstate New York region, which is where most of the Plan's participants reside and seek medical service. However, many of the Plan's retirees that are enrolled in one of the Retiree Buy-In Plans, reside outside the upstate New York region. Participants who live outside the upstate New York region are strongly encouraged to call Aetna prior to seeking any medical services.

Retiree Buy-In participants are required to pre-certify with Aetna for all hospital and other inpatient facility services, elective (scheduled) surgeries, specialized testing and therapy services and durable medical equipment over $2,500.00. For pre-certification requirements you must call Aetna at 1-888-632-3862.

Pre-certification gives the Fund prior knowledge of a pending hospital stay or out-patient surgery, thereby allowing Aetna to contract directly with the service providers that will be involved with your care. Aetna can then confirm that the care you are going to receive is in accordance with standard medical procedures, that the services are covered by the Health Fund, and to potentially negotiate fee reductions.

MEDICAL SERVICES REQUIRING PRE-CERTIFICATION

- Hospital and other inpatient facility services.
- All elective (scheduled) surgeries.
- Specialized testing including but not limited to MRI, Nerve Conduction or EMG tests.
- Therapy Services.
- Durable Medical Equipment over $2,500.00.

If you fail to pre-certify, this will result in a maximum of $1,000.00 deductible for each occurrence. Pre-certifying may save you out-of-pocket costs as well as preserve the assets of the Fund.

If you have not received an identification card, or you lost or misplaced your identification card, please call the Health Fund Office at (315) 492-1796.

ARTICLE VIII – HOSPITAL BENEFITS

The Health Fund will pay 90% of the usual, customary and reasonable charges incurred at a hospital facility for inpatient confinements and ambulatory surgeries (so long as the surgery is recommended, approved and performed by a qualified licensed surgeon). The annual Major Medical deductible shall not apply to these hospital charges.

The following hospital services are paid at 80% of the usual, customary and reasonable charges after the Major Medical deductible is applied: Medicine, Diagnostic tests, Ambulance, Dialysis, Private Duty Nursing, Physical Therapy, Radiation and Chemotherapy, Laboratory Testing, Anesthesia, Hospital Clinics and Emergency Room.

Notwithstanding, if you receive Surprise Services, the most you will be required to pay is the 10% or 20% coinsurance of the Qualifying Payment Amount, depending on the services you receive.

Federal Law generally prohibits group health plans from restricting benefits or newborn infant charges for any length of stay in a hospital in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal Law generally does not prohibit the mother's or the newborn's attending provider, after consultation with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable).

ORGAN TRANSPLANTS - The Hospital benefit includes coverage for the costs incurred by both the donor and recipient for a life-saving medically necessary organ transplant, consistent with the provisions of this subsection, provided the recipient is a Covered Person of this Plan.

Subject to any limitations or exclusions in this SPD, covered expenses include hospital and physicians charges for both the donor and recipient, as well as reasonable costs associated with the

acquisition and procurement of the organ. Complications, side effects or injuries sustained by the donor are not covered unless the donor is a Covered Person under this Plan.

In addition, if the recipient lives more than 50 miles from an in-network transplant facility, and/or if the living donor lives more than 50 miles from the transplant facility chosen by the recipient, the Fund will cover reasonable travel and lodging, up to a maximum amount of $10,000. Such expenses will be paid for the donor and/or recipient and:

- One parent (if the donor and/or recipient is a Dependent Child, as defined in this Plan); or
- One adult to accompany an adult donor and/or recipient.

Covered travel and lodging expenses include the following:

- Transportation to and from the transplant facility, including:
- The cost of coach airfare, but only if it's determined by the Fund that the air travel is reasonable under the circumstances;
- Tolls and parking fees at the transplant facility;
- Gas/mileage from the person's house, to the transplant facility if travel is by automobile;
- Lodging at or near the transplant facility, up to a maximum of $50 per person per day and only for as long as necessary, as determined by the Fund in its sole and absolute discretion.

The Fund will only cover expenses of a non-covered living donor after any other coverage for that living donor has been exhausted.

<u>Transplant Exclusions</u>

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ to a recipient who was not a Covered Person under this Plan.
- Transplants considered experimental, investigational or unproven, except as required by law.
- Transplants that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

Continuing Care Patients

If an Aetna provider leaves the network, you may continue to receive treatment from that provider for a limited period of time as if the provider remained in the Aetna network, provided you are

considered a "Continuing Care Patient" and you timely make an election to be so treated. A Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a Serious and Complex Condition (defined below); (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

To be treated as a Continuing Care Patient, you must properly complete an election form and return it to the Fund Office within 30 days of the date on which it is provided to you. Once the Fund Office receives a properly completed election form, it will determine whether you meet the requirements for Continuation of Care. If you are considered a Continuing Care Patient and timely make an election, services rendered by that provider will be treated as "in-network" until the earlier of: (i) the 90th day after the provider left the network or you were provided with a Continuation of Care notice and election form, whichever is later; or (ii) the date on which you no longer need treatment for the condition that made you a Continuing of Care Patient.

Serious and Complex Condition means: (1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

No Surprises Act

The following definitions apply to this Article VIII:

Ancillary Services means, with respect to services provided at an in-network Aetna provider facility and except to the extent excluded by applicable law, covered services that are (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; (4) items and services provided by a non-participating provider if there is no provider in the Aetna network that can furnish such item or service at such facility; (5) other services defined as ancillary under the No Surprises Act and its implementing regulations.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services means any of the following, with respect to an Emergency Medical Condition

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;
- Further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished);

- Post-stabilization services following an Emergency Medical Condition to the extent required by applicable law.

Health Care Facility. For non-Emergency Services, means a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

Independent Freestanding Emergency Department means a facility that is geographically separate and distinct from a hospital that is licensed under applicable State law to provide Emergency Services.

Notice and Consent with respect to covered services rendered by a non-participating provider at a Health Care Facility that participates in the Aetna network, Notice and Consent means: (1) that you are provided with a written notice consistent with the requirements of federal law (generally stating that the provider is a non-participating provider, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed) and (2) you give informed consent to continued treatment by the non-participating provider, acknowledging that you understand that continued treatment by the non-participating provider may result in greater cost to you.

Surprise Services means the following services, to the extent required by applicable law and to the extent they are covered services under the Plan: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) non-emergency Ancillary Services when performed by non-participating providers at Aetna Provider facilities; and (4) other out-of-network non-Emergency Services performed by a non-participating provider at an Aetna Provider facility with respect to which the Notice and Consent requirements have not been met

Qualified Payment Amount ("QPA") generally means the median of the in-network rates payable for a particular service as of a particular date, based on Aetna's book of business. In all cases, QPA shall be determined consistent with applicable federal law and any regulations issued thereunder.

You will not be required to pay more than the lesser of (1) your coinsurance obligation or (2) the provider's billed charges for Surprise Services that are covered under the Plan.

ARTICLE IX – MAJOR MEDICAL BENEFITS

A. GENERAL - Most of the benefits provided by the Health Plan are called Major Medical Benefits. Major Medical coverage is payable at 80% of the usual, customary and reasonable charges after the payment of a deductible. The Major Medical deductible for all participants and eligible dependents is $100.00 per person annually. The deductible applies separately to each eligible person. The Plan provides an annual Major Medical deductible cap of $400.00 per active eligible family.

B. FAMILY OUT-OF POCKET MAXIMUM - Each family will be responsible for no more than $2,000.00 out-of-pocket medical expenses during each calendar year. If the family has paid $2,000.00 in medical expenses, then all further medical expenses during the balance of the calendar year will be covered at 100% of the usual, customary and reasonable charges. The out-of-pocket expenses include only deductibles and the co-insurance amounts made by you after the Plan pays 80% or 90% charges.

EXCLUSIONS TO OUT OF POCKET EXPENSES

1. Prescription Drug Co-Payments
2. Nursing Home charges
3. Payments by other insurance carriers
4. Charges in excess of usual, customary and reasonable charges
5. Charges in excess of the allowable amounts for durable medical equipment and repairs
6. Dental Benefits
7. Vision Benefits
8. Hearing Aid Benefits

C. CHARGES RELATED TO A MASTECTOMY - Your Major Medical coverage includes charges incurred by a Participant or Dependent in connection with a mastectomy covered by the Plan, in a manner determined in consultation with the attending physician and the participant or the dependent, for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas, provided the participant or dependent elects breast reconstruction in connection with such mastectomy.

ARTICLE X – PRESCRIPTION DRUG BENEFIT

GENERAL - The Fund offers a Prescription Drug benefit to eligible participants and dependents which is administered by OptumRx. Many national pharmacy chains and independent pharmacies are included in the OptumRx network. For a complete list of participating pharmacies, use the OptumRx Pharmacy Locator tool on the OptumRx App, at Optumrx.com or call OptumRx customer service at 1-855-295-9140. In addition, OptumRx offers a Mail Order Service for eligible participants and dependents who are using maintenance prescription drugs. To start mail order home delivery for maintenance medications log in to OptumRx.com, use the OptumRx App or call 1-855-295-9140.

SPECIALTY MEDICATIONS - Briova Rx is the OptumRx specialty medications pharmacy, BriovaRx provides specialty medications and some clinical support for certain conditions. All specialty medications must be purchased through BriovaRx. To contact BriovaRx about specialty medications please call 1-855-427-4682 or visit BriovaRx.com.

ACTIVE PARTICIPANT AND DEPENDENT COVERAGE - Eligible active participants and dependents may purchase generic drugs subject to a $20.00 co-pay per prescription, covered preferred brand name drugs subject to a $40.00 co-pay per prescription, covered non-preferred brand name drug subject to a $75.00 co-pay per prescription, and covered lifestyle drugs, (i.e. Viagra, Cialis) subject to a 50% co-pay per prescription for both retail and mail order purchases.

WIDOWED SPOUSE AND RETIREE BUY-IN PARTICIPANT COVERAGE - Individuals who participate in the Widowed Spouse Buy-In and Retiree Buy-In Programs will be covered for certain prescription drugs that are purchased at a participating pharmacy or the Mail Order Service, subject to the payment of 20% of the cost of the drug. The Fund pays the remaining 80% of the prescription cost. However, the co-pay applicable to covered lifestyle drugs (i.e. Viagra, Cialis) is 50% of the cost of the drug.

There is a cost savings advantage to you, as the consumer, when you purchase a generic equivalent to a brand-name drug. Prior to filling your prescriptions, you should discuss with your provider whether there is a generic equivalent that may be used.

ADDITIONAL INFORMATION - For more information about the Prescription Drug benefit, or if you have not received, or lost, or misplaced your prescription drug card, please contact the Fund Office.

NO BENEFITS WILL BE PAID FROM THIS PLAN FOR THE FOLLOWING:

1. Non-Legend Drugs other than Insulin;
2. Drugs, vitamins and diet supplements
3. Drugs related to smoking cessation;
4. Rogaine and any other hair loss or hair restoration products;
5. Unauthorized refills;
6. Excessive refills;
7. Appliances, other than specialized bandages, braces splints, syringes and needles not available without a prescription.
8. Drugs that are considered experimental or have not been approved by the FDA, except to the extent required by law:
9. Fertility Drugs, except that out-of-pocket costs related to fertility drugs may be reimbursed through the Fund's HRA.
10. Drugs that can be purchased over the counter.
11. Drugs and/or Appliances purchased from a pharmacy that does not participate in the OptumRx network.
12. Specialty Drugs that have not been pre-certified though OptumRx.

If you and/or your eligible dependents have other Primary Insurance, you must submit your prescription drug claim to the other insurance carrier for reimbursement first. The Fund does not reimburse the portion of the prescription drug cost or co-pay that the other Primary Insurer does not cover. However, you may submit that portion not covered by your Primary Insurance carrier for reimbursement from your balance in the HRA. (See Article XII.)

To the extent permitted by applicable law, on the first day of the month in which you or your eligible spouse attains the age of 65, and you are eligible for Medicare, the prescription drug benefit will cease.

NOTE: Eligible participants and/or dependents who have prescription drug coverage through another Primary Insurance carrier are not eligible to purchase prescription drugs, using the Prescription Drug Card provided by the Fund. Should you use the Prescription Drug Card to purchase prescription drugs that should be covered by your Primary Insurance carrier; you will be responsible to reimburse the Fund the full portion of the prescription drug cost. In the event your other Primary Insurance carrier does not provide prescription drug coverage, has terminated the prescription drug coverage or has added prescription drug coverage, a notice from the insurance carrier stating such is required to be submitted to the Health Fund.

ARTICLE XI – OTHER BENEFITS

A. DOCTOR'S OFFICE - Doctor's office visits are paid at 80% of the usual, customary and reasonable charges and include:

- Home and Office Visits
- Remote Office Visits
- Diagnostic Tests
- Well Baby Care
- Allergy Tests
- Injections
- Surgeons
- Routine Physical Examinations
- Pediatricians
- Chiropractors (limit 10 visits per calendar year)
- Obstetricians
- Acupuncture (limit 10 visits per calendar year)

B. HOME HEALTH CARE - The following Home Health Care services are paid at 80% of usual, customary and reasonable charges:

- Physical Therapy
- Private Duty Nursing
- Medical Supplies*
- Durable Medical Equipment**

* Medical supplies are limited to:

- Oxygen
- Blood Transfusions
- Specialized bandages and surgical dressings
- Ostomy bags and supplies required for their use
- Catheters
- Syringes and Needles necessary for conditions such as diabetes
- Specialized surgical dressings for treatment of conditions such as cancer, diabetes, ulcers, infections and burns.

** The use of the following Durable Medical Equipment is covered:

- Canes, Casts, Splints, Braces and Crutches
- Wheelchair
- Hospital Bed
- Equipment for the administration of oxygen and respirators
- Mechanical equipment for the treatment of respiratory paralysis
- Walkers
- CPAP device

NOTE: When you require the use of such equipment, you must contact the Fund Office so the Fund Office can determine whether the equipment should be rented or purchased for your use. If the Fund Office determines that the equipment should be purchased, then replacement costs will also be reimbursed at 80% of the usual, customary and reasonable charges, subject to medical necessity. Delivery and/or service charges of equipment is not covered.. Maintenance and repair costs are not covered, except:

1. Maintenance and repair costs for wheelchairs;
2. Maintenance and repair of equipment that is surgically implanted in an individual; and
3. The costs to repair a continuous positive airway pressure ("CPAP") machine, provided (1) the cost to repair the machine is less than the cost to replace the machine and (2) the need for the repair is due to normal wear and tear and not from misuse or abuse of the machine.

Maintenance and repairs costs associated with all other durable medical equipment are not covered under the Plan.

The following conditions and exclusions apply with respect to both Durable Medical Equipment and Medical Supplies:

- The item must be used for medical purposes;
- The item must be of substantial therapeutic value in the treatment of your condition and of use to you only;
- The item must generally not be useful to a person in the absence of injury or illness; and
- The item must be ordered by a physician.

C. MENTAL AND NERVOUS DISORDER BENEFIT - Inpatient, partial hospitalization and outpatient expenses for the treatment of acute mental, nervous and substance use disorder conditions (like medical conditions) are covered subject to the general limitations and exclusions of the Plan.

A mental and nervous disorder means any disease or condition that is classified as mental disorder in the current edition of International Classification of Diseases, published by the Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

The Plan covers Mental and Nervous Disorder expenses, including Hospital professional charges for group, family, individual or related therapists based upon the following schedule of benefits:

Inpatient: Paid at 90% of the usual, customary and reasonable charges. All claims are subject to utilization review by the Fund Office or its designated managed care provider, but only if utilization review is required for comparable medical care.

Outpatient: Paid at 80% of the usual, customary and reasonable charges. All claims are subject to utilization review by the Fund Office or its designated managed care provider, but only if utilization review is required for comparable medical care.

The Plan covers Mental and Nervous Disorder expenses incurred for the following services:

* facility services, supplies and prescription drugs administered during the treatment session;
* Physician services;
* Psychiatric nurse or social work services; and
* Psychological testing.

Notwithstanding, a Mental and Nervous Disorder that is a Surprise Service will be covered consistent with the provisions for Surprise Services as described in Article VIII.

EXCLUSIONS AND LIMITATIONS - Mental and Nervous Disorder expenses that are not covered under the Plan include, but are not limited to:

- missed appointments;
- telephone consultations;
- consulting or therapy not primarily part of the institution's care or which are for educational, vocational training, recreation therapy or used to assist with custodial care;
- charges for maintenance care of chronic mental illness, provided such exclusion applies to comparable medical care;
- charges in excess of the maximum allowable, including charges in excess of the amount determined by utilization review;
- charges for non-eligible dependents; and
- personal comfort items

D. OTHER COVERED SERVICES

- Orthopedic Braces
- Prosthetics
- Speech Therapy
- Neurologists
- Urologists
- Podiatrists
- Accidental injury to Natural Sound Teeth (within 90 days of accident)
- Flu Vaccinations (administered at a retail pharmacy in the OptumRx network)

E. SELF-INSURED DEATH AND DISMEMBERMENT BENEFITS - Active participants who are eligible for benefits from the Fund through regular eligibility are covered for the self-insured benefits as described below under the **Pre-Retirement Surviving Spouse Death Benefit** and the **Death and Dismemberment Benefit:**

1. **PRE-RETIREMENT SURVIVING SPOUSE DEATH BENEFIT -** In the event of an eligible Participant's death prior to his or her retirement, his or her surviving spouse (who must have been married to the deceased Participant for at least one year prior to the Participant's death) shall be paid a $10,000.00 death benefit.

2. **DEATH AND DISMEMBERMENT BENEFIT -** In addition, the Designated Beneficiary of a participant who dies while covered through regular eligibility shall be paid a $10,000.00 death benefit.

This Death benefit will be paid in accordance with your beneficiary designation on your enrollment card. If no beneficiary designation has been made, or if your beneficiary predeceases you, this death benefit shall be paid as follows:

1. If more than one beneficiary is named, each will be paid in equal shares

2. If any named beneficiary dies before you do, his or her share will be divided equally among the named beneficiaries who survive you.

3. If you are not survived by a duly designated beneficiary, this death benefit will be paid as follows:

    (a) First – To your widowed spouse; or if the widowed spouse is not living, then,

    (b) Second – To your children in equal shares; or if you do not have any children, then,

    (c) Third – To your parents in equal shares, or to your brothers and sisters in equal shares if your parents are deceased, then,

    (d) To your duly appointed and qualified executor or administrator, or if no executor or administrator is appointed and qualified within sixty (60) days following receipt by the Trustees of the notice of death of participant, then,

    (e) The Trustees will take appropriate action to obtain a judicial determination as to the distribution of this death benefit.

An eligible participant shall be paid a dismemberment benefit as a result of certain accidental injuries.

An accidental injury is an injury suffered while your coverage was in force which:

1. results directly in a covered loss from such injury independent of all other causes; and

2. that loss occurs within ninety (90) days after the date of the accidental injury.

The following injuries are excluded from the dismemberment benefit:

1. any sickness, illness or disease; or

2. any loss caused by medical treatment in (1); or

3. any infection, except a pus infection of an accidental cut or wound; or

4. war or any act of war whether declared or not; or

5. any intentionally self-inflicted injury, suicide or suicide attempt; or

6. alcoholism or drug addiction.

Death and Dismemberment benefits are payable for the following losses according to the schedule below. Dismemberment Benefits for all losses other than death will be paid to the participant. No benefit is payable for any loss which is not shown in the schedule.

DESCRIPTION OF LOSS	BENEFIT
Loss of Life	$10,000.00
Loss of One Hand	$5,000.00
Loss of One Foot	$5,000.00
Loss of One Eye	$5,000.00
More than one of the above resulting from an accident	$10,000.00

The Maximum Lifetime Benefit is $10,000.00

Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint. Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.

F. DENTAL BENEFITS - The Fund's dental benefits are administered through a contract with Delta Dental. You are not required to use a Delta Dental Provider. However, choosing a Dentist that is within the Delta Dental Provider network saves money for both you and the Plan because Delta Dental providers have agreed to a fixed fee schedule. To find a Dentist within the Delta Dental network, you may call the Delta Dental Customer Services Line toll-free at (800) 932-0783 or visit their website at www.deltadentalins.com

1. **Covered Charges -** Covered Dental Expenses incurred by you and your Eligible Dependents will be paid according to the Delta Dental Schedule of Benefits. Covered Dental Expenses include the charges of a Dentist that the patient is required to pay, up to the Maximum Plan Allowance, meaning the contracted maximum amount payable for each service. However, the benefit payment will not be more than the amount shown in the Delta Dental Schedule of Benefits. When you visit a Delta Dental Provider, you are responsible to pay the difference between the Delta Dental Maximum Plan Allowance and the Maximum Allowance listed in the Schedule of Benefits. When you visit a non-participating provider, you are responsible to pay the difference between the amount billed and the Maximum Allowance listed in the Schedule of Benefits.

   The Fund provides coverage for Covered Dental Expenses up to a maximum of $1,000.00 in Covered Dental Expenses per covered life per calendar year. There is no deductible for the dental benefits. Pediatric dental benefits (up to age 19) are not subject to the $1,000.00 annual maximum, but the Fund does not cover orthodontics for children or adults. After a participant or beneficiary reaches the $1,000.00 annual dental maximum, that individual will continue to receive the network discounts available to the Fund through its arrangement with Delta Dental.

However, the Fund will not pay the cost of any dental services during that year once the $1,000.00 annual maximum has been reached.

2. Additionally, the benefits provided by Delta Dental network providers are subject to co-payments as summarized in the following chart.

SUMMARY OF CO-PAYMENTS

SERVICES PERFORMED		DELTA DENTAL	PARTICIPANT
I.	Diagnostic	100%	0%
II.	Preventative	100%	0%
III.	Basic Restorative	80%	20%
IV.	Major Restorative	50%	50%
V.	Oral Surgery*	80%	20%
VI.	Endodontics	80%	20%
VII.	Non-Surgical Periodontics	80%	20%
VIII.	Prosthodontics	50%	50%
IX.	Orthodontics	0%	100%
X.	Surgical Periodontics	80%	20%
XI.	General Anesthesia	80%	20%
XII.	Temporomandibular Joint Dysfunction	0%	100%
XIII.	Sealants	100%	0%

Certain Oral Surgery procedures are covered under the Plan's Major Medical benefit. For more information call the Fund Office.

For more detailed information about the Dental Expenses that are covered and at what rates, including information about covered diagnostic aids, like intraoral films, contact Delta Dental or the Fund Office.

2. **Diagnostic and Preventative Services -** Covered Dental Expenses for Diagnostic and Preventative Services provided by a Delta Dental Provider will be covered at 100% of the Delta Dental Maximum Plan Allowance. Covered Dental Expenses for Diagnostic and Preventative Services provided by a non-participating Dentist will be covered at 80% of the Prevailing Fee. Choosing a Delta Dental Provider will also offer a smaller co-payment for the patient. If two or more dental services are rendered, payment will be made for each dental service unless the Schedule of Benefits specifies a maximum amount for a particular combination of dental services.

3. **Non-Diagnostic and Preventative Services -** Covered Dental Expenses for Services other than Diagnostic and Preventative Services will be paid according to the Maximum Allowance shown in the Delta Dental Schedule of Benefits. For more detailed information about the Delta Dental Schedule of Benefits, contact Delta Dental or the Fund Office.

4. **Extended Benefits -** There is no dental coverage after the termination of eligibility. However, Covered Dental Expenses will be payable for charges for at least thirty (30) days or until the services are complete for any treatment commenced before the termination of eligibility. For example, coverage shall be

extended for prosthetic devices (including bridges and crowns), and the fitting thereof, which were ordered while the Covered Person was eligible for benefits with Delta Dental, but are installed or delivered to such Covered Person within thirty (30) days after the eligibility termination date.

5. **Benefit Limitations -** Delta Dental will not process any claims submitted more than twelve (12) months after the date of providing the service. Additionally, benefit payments will not be made for any expenses incurred for the following:

   a. Charges for any dental procedures included as a covered medical expense;

   b. Charges for the treatment by someone other than a Dentist, excluding cleaning or scaling of teeth which may be performed by a Dental Hygienist;

   c. Charges for any replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, unless satisfactory evidence is presented that:

      i. The replacement or addition of teeth is required to replace one or more natural teeth extracted while eligible under the Plan, or

      ii. The existing denture or bridgework was installed at least 48 months prior to its replacement, or

      iii. The placing of an initial denture necessitates the replacing of an existing opposing denture;

   d. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;

   e. Charges for the replacement for a lost or stolen prosthetic devise; and

   f. Charges for any services or supplies that are for orthodontic treatment (including correction of malocclusion), except as provided for in the Schedule of Benefits.

In addition to the limitations set forth above, dental benefits are subject to other restrictions and exclusions established by the Fund. To receive more information about these limitations, restrictions, and exclusions, contact Delta Dental or the Fund Office.

Dental benefits are available for active eligible participants and their dependents. There are no dental benefits for participants enrolled in the Voluntary Buy-In Plan, the Widowed Spouse Plan or enrolled in any of the Retiree Buy-In Plans.

6. **Definitions -** The following definitions apply to these Dental Benefits:

“Dental Expense” means the part of the charge for dental services that meets all of the following conditions:

1. Is covered under the Dental Expense Benefit,

2. Does not exceed the Prevailing Fee for the service, and

3. Is incurred while the patient is eligible for the Dental Expense Benefit.

“Dental Hygienist” means a duly licensed dental hygienist who works under the supervision of a Dentist.

“Dentist” means a duly licensed dentist or physician who is operating within the scope of a dentist’s or physician’s license.

“Prevailing Fee” means a charge for Dental Expenses that does not exceed the 90th percentile of the Plan’s prevailing health care data.

G. HEARING AID BENEFIT - Active participants, retirees participating in the Early Retiree Buy-In Plan, the Normal Buy-In Plan, Widowed Spouse Buy-In Plan, Disability Retiree Buy-In Plan and their eligible dependents are eligible for an allowance towards the cost of purchasing hearing aids. The allowance is up to $1000.00 during any three consecutive year period for the purchase of one hearing aid or up to $2000.00 during any three consecutive year period for the purchase of two hearing aids.

This allowance will be paid directly to you after the Fund Office has received confirmation from your provider that the return period has expired and the hearing aids have not been returned. This allowance can be used to reimburse you for the cost of the hearing aid device, and preliminary exam. The allowance cannot be used to replace lost or stolen hearing aids, for repairs, batteries or other services. This benefit is subject to all other applicable exclusions of the Plan.

Note: Submit your I.D. card to your hearing aid provider.

H. VISION BENEFITS - Active participants, retirees participating in the Early Retiree Buy-In Plan, the Normal Retiree Buy-In Plan, Widowed Spouse Buy-In Plan, Disability Buy-In Plan and their eligible dependents are eligible for vision benefits. This benefit is administered by Davis Vision (Empire Vision Works).

In-Network Benefit **-**The Fund will cover, in full, one eye examination during a 12 consecutive month period with a Davis Vison Provider. You will also receive coverage for one pair of prescribed eye glasses per 12 consecutive month period from either the “fashion” or “designer” collection levels, or one set of collection contact lenses. A set of contact lenses means 4 boxes of disposable lenses or 2 boxes of planned replacement lenses. In addition, active participants are eligible for one pair of safety glasses during any 12 consecutive month period. (Safety glass benefits are not applicable to dependents or any non-active participant). There are additional charges and limits that apply to non-collective or “premier” eyeglasses or contact lenses, as well as certain enhancements. If you have any questions about your expected out-of-pocket costs please contact Davis Vision Member Services at 800-999-5431 or at memberhelp@davisvision.com.

Out-of-Network Benefit **-** If you use a provider that does not participate in the Davis Vision network, the Fund will reimburse you, during any 12 consecutive month period, up to a maximum of $40.00 towards the cost of an eye examination, up to $50.00 towards the cost of frames, up to

$40.00 towards the cost of single vision lenses (up to $60.00 for bifocal lenses, up to $80.00 for trifocal lenses and up to $100.00 for lenticular lenses) and up to $105.00 towards the cost of contact lenses. If you use an out-of-network provider, you will be required to pay your provider directly and then submit a claim form to Davis Vision for reimbursement. The address to submit claims is: Vision Care Processing Unit, P.O. Box 1525, Latham, New York, 12110. To obtain claim forms call 800-999-5431. You can download claim forms at memberhelp@davisvision.com or call the Fund Office.

I. SUBSTANCE USE COVERAGE

Effective April 1, 2021, the Plan will cover the cost of medically necessary substance use disorder treatment. For in-patient treatment, the Fund will cover 90% of the usual, customary and reasonable charges. All claims are subject to utilization review by the Fund Office or its designated managed care provider, provided that utilization review is required for comparable medical care. For outpatient treatment, the Fund will cover 80% of the usual, customary and reasonable charges. All claims are subject to utilization review by the Fund Office or its designated managed care provider, provided that utilization review is required for comparable medical care.

Inpatient, partial hospitalization and outpatient expenses for the treatment of substance use disorder are covered subject to the general limitations and exclusions of the Plan.

A substance use disorder means any disease or condition that is classified as substance use disorder in the current edition of International Classification of Diseases, published by the Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

The Plan covers substance use disorder expenses incurred for the following services:

* facility services, supplies and prescription drugs administered during the treatment session;
* Physician services;
* Psychiatric nurse or social work services; and
* Psychological testing.

Notwithstanding, a Substance Use Disorder that is a Surprise Service will be covered consistent with the provisions for Surprise Services as described in Article VIII.

EXCLUSIONS AND LIMITATIONS - Substance use expenses that are not covered under the Plan include, but are not limited to:

- missed appointments;
- telephone consultations;
- charges for maintenance care of substance use disorder;
- charges in excess of the maximum allowable, including charges in excess of the amount determined by utilization review;
- charges for non-eligible dependents; and
- personal comfort items

J. COVID-19 COVERAGE.

COVID-19 Vaccinations

The Plan will cover the cost to administer an immunization intended to prevent or mitigate the coronavirus (COVID-19) disease, provided the immunization has received either (i) a recommendation from the U.S. Preventive Services Task Force or (ii) a recommendation from the Advisory Committee on Immunization Practice, which has been approved by the CDC ("Coronavirus Vaccine"). If the Coronavirus Vaccine is administered by a provider that participates in the Plan's PPO network with Aetna or a pharmacy that participates in the Plan's PBM network with OptumRx, the Plan will cover the vaccine administration fee at 100% of the negotiated rate. If the Coronavirus Vaccine is administered by any other provider, the Plan will cover the administration cost up to a maximum of the amount that would be reimbursed by Medicare for the administration of the vaccine.

Under federal law, you are not required to pay any amounts out-of-pocket related to a Coronavirus Vaccine.

This coverage is effective for any Coronavirus Vaccine administered on or after January 1, 2021 and will remain in effect only for as long as the ingredient costs of the Coronavirus Vaccine continue to be fully subsidized by the Federal Government.

COVID-19 Testing

During the course of the federally declared Public Health Emergency related to COVID-19, the Fund will cover claims, consistent with the terms described herein, for: (1) diagnostic products for the detection of SARS-CoV-2 or the diagnosis of COVID-19 that are approved, cleared or authorized by the FDA, and the administration of such diagnostic products; (2) items and services furnished to you during health care provider office visits (including telehealth visits), urgent care visits, and emergency room visits that result in an order for, or administration of, such a diagnosis product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test; (3) in vitro diagnostic testing for which a developer has requested, or intends to request, emergency use authorization from the Food and Drug Administration ("FDA"), unless such request has not been timely submitted to the FDA for consideration or until such request has been denied by the FDA; (4) in vitro diagnostic testing authorized by a State that has notified the Secretary of Health and Human Services ("HHS") of its intention to review such tests to diagnose COVID-19; and (5) any COVID-19 diagnostic testing that the Secretary of HHS determines to be appropriate and for which guidance has been issued.

Beginning January 15, 2022 and continuing through the federally declared Public Health Emergency, the Fund will provide coverage for FDA authorized over the counter COVID tests ("OTC Tests") through the Fund's prescription benefit program with OptumRx. The Fund will provide coverage for up to 8 tests per covered person per month. If you purchase a package with two tests inside, that is counted as two tests. You are not required to have a prescription from your health care provider to receive this coverage.

Through this program, if you purchase a test at the pharmacy counter of any pharmacy that participates in this program and present your member identification card, you will not be charged for the OTC Test – it will automatically be reimbursed in full at the point of sale, with no co-

payment, co-insurance or other out-of-pocket costs. Alternatively, you can order OTC Tests online from OptumRx and have them shipped directly to your residence at no cost to you.

If you purchase an OTC Test through a non-participating retail establishment or online other than from OptumRx, you will be required to pay for the cost of the OTC Test at the point of sale. You may then submit a reimbursement for up to $12 per test.

ARTICLE XII – HEALTH REIMBURSEMENT ACCOUNT

A. GENERAL - The Health Reimbursement Account (HRA) is an individual account that is maintained for each participant who is working for an employer that is required by Collective Bargaining Agreements and/or Participation Agreements to contribute to the Plan.

You must first become eligible for medical benefits under this Plan to be eligible to receive reimbursements from your balance in the HRA. Also, if your coverage under this Plan ends, HRA contributions made on your behalf after the loss of coverage will not be available to you until you become eligible again for medical benefits.

However, if the Collective Bargaining Agreement that governs your employment is subsequently modified to eliminate or reduce to a minimum amount of future contributions to the Fund, your balance in the HRA will be forfeited and you will no longer be eligible for HRA so long as that Collective Bargaining Agreement governs your employment.

You may opt out of having future contributions made on your behalf to the HRA at any time. In the event you opt-out, you will forfeit any remaining HRA balance and your right to future reimbursements from the HRA.

B. CLAIM PROCEDURES - Claims for reimbursement must be made on HRA forms that are available at the Fund Office or your Local Union Office. You can obtain claim forms by mail or in person. All claims must be for an aggregate minimum of $25.00.

C. BENEFITS - If you, your spouse or your eligible dependent children under the age of 26 incur any medical, dental or optical expenses that are not reimbursed by the Fund, or any other health insurance plan, you may withdraw the unreimbursed amount from your HRA balance. Unreimbursable amounts include, but are not limited to, deductibles and co-payments, including prescription drug co-payment.

In addition, you may withdraw from the HRA balance to pay for the premiums incurred for the Participant Buy-In Plan (Voluntary Buy-In Plan), any of the Fund's Buy-In Plans, or COBRA premiums (Member, Spouse and dependent Children only), upon your written request.

The Fund will not reimburse any claims that were incurred more than three (3) years before the date the Fund receives a properly completed reimbursement request. All claims must be for an aggregate minimum of $25.00

When you are applying for reimbursement from the HRA, the Fund Office must be provided with the following:

1. A copy of the Explanation of Benefits forms(s), showing the amount the other insurance carrier(s) paid or rejected. *If you do not have the Explanation of Benefits form(s) from Aetna only, the Fund Office will include a copy of your

EOB with your reimbursement request, provided the EOB form was issued under your coverage with the Fund;

2. Proof of co-payment you paid to the provider/pharmacy;

3. A copy of a bill if an EOB is not available;

4. A properly completed HRA claim form;

5. Any other documentation the Fund Office requires with respect to a particular claim.

All reimbursements from the HRA will be paid directly to the eligible participant. No payments will be made to any other entity.

D. FOREFITURE OF SMALL ACCOUNTS - Because of the expense of administering the individual accounts, any account that does not maintain a balance of least $25.00 over a period of 24 consecutive calendar months will be forfeited and used to pay health care and other benefits provided by the Health Fund.

If you are not covered under the Plan as an active participant, retiree buy-in participant, widowed spouse or Medicare supplement participant and your balance in the Fund's HRA is $500 or less at any time and you have no activity with respect to HRA (contributions made to, or reimbursements made from the HRA) for at least three consecutive 12 month periods, your account balance will be permanently forfeited on the first day of the next Plan year.

E. ADMINISTRATION - If investment returns exceed administrative expenses, the Board of Trustees may declare a distribution that would be applied pro rata to each individual account.

ARTICLE XIII – SECOND AND THIRD OPINION PROGRAM

Any participant or eligible dependent may seek a second, or if necessary, a third opinion from a qualified surgeon regarding any proposed covered surgical matter. The charges for the second and/or third opinion will be paid in full.

The federal government has set up a toll free number (1-800-638-6833) to help locate specialists near you.

ARTICLE XIV – EXCLUSIONS AND LIMITATIONS

NO BENEFITS WILL BE PAID FROM THIS PLAN TO COVER THE FOLLOWING, UNLESS OTHERWISE REQUIRED TO BE COVERED UNDER APPLICABLE FEDERAL LAW, IN WHICH CASE IT IS COVERED TO THE EXTENT NECESSARY TO COMPLY WITH SUCH LAW:

1. Services and or supplies that are not medically necessary as determined by the Board of Trustees in its sole discretion.

2. Services or supplies not given to treat your sickness or injury.

3. Charges for services or supplies not actually rendered (including charges for missed or cancelled appointment).

4. Services or supplies that were rendered before you became a covered individual.

5. Charges incurred during a period in which you are not covered by the Fund.

6. Services rendered to a newborn dependent who is not eligible to enroll in the Plan.

7. Confinement, treatment, services or supplies provided by or in a United States Government, or other governmental hospital, to the extent permitted by law.

8. Services provided by an individual in your family, or your spouse's family.

9. Expenses for services not prescribed.

10. Charges for a private hospital room unless such a room is determined to be medically necessary and was prescribed by a licensed physician.

11. Service and supplies rendered by individuals or entities other than qualified hospitals, physicians, and other medical providers.

12. Services for which you had other health insurance coverage, or for which some other third party is responsible, in accordance with other provisions of this Plan.

13. Injuries or sickness developing from or directly attributed to your employment, or ailment or injury arising out of and in the course of your employment, for which there is Worker's Compensation or Occupational Disease Law Coverage.

14. Services, treatment methods, drugs or procedures, including organ transplants, which this Plan determines are experimental, investigative, controversial, or not recognized as accepted medical practices by the American Medical Association, or an appropriate medical board. Any care or treatment considered experimental by the U.S. Food and Drug Administration, the American Medical Association or the Health Care Financing Administration is excluded. Any drug not approved or declared safe and effective by the Food and Drug Administration or labeled "Caution-Limited by Federal Law to Investigational Use" is excluded.

15. Charges that are payable by a third party including but not limited to, Professional Liability Insurance, Motor Vehicle Liability Insurance, Individual or Group Liability Insurance and Homeowners Liability Insurance.

16. To the maximum permitted by law, no benefit or plan assets will be paid or expended from this Plan to cover expenses related to an injury, condition or disease resulting from directly or indirectly being engaged in or incurred while committing an illegal act. For the purpose of this exclusion, the term "Illegal act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether an action or omission is an illegal act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the term "Illegal act" shall not be interpreted to exclude coverage

related injuries incurred as a result of domestic violence and/or self-inflicted injuries that are a result of depression or mental illness.

17. Charges that you are not legally required to pay and that you would not be required to pay if you did not have the benefits under this Plan.

18. Diet supplements, or diet weight loss programs

19. Personal comfort or entertainment items, such as televisions, telephones, contour furniture, air conditioners, trips or relocation to different climates, etc.

20 Health clubs, exercise equipment, swimming pools, bath massages, whirlpools, treadmills, joggers, phase III cardiac rehabilitation programs, tanning equipment, environmental control equipment, and/or other non-medical equipment.

21. Charges for home reconstruction, including those arising from special medical treatments in the patient's home.

22. Service for which payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, to the extent permitted by law.

23. Services for cosmetic surgery, except to the extent required by law.

24. Breast implants (except following a mastectomy), and breast enlargements.

25. Hypnotherapy.

26. Hair replacement or removal, including the costs of minoxidil when used in the form of a topic solution, including Rogaine.

27. Treatment (including surgery) that has a primary purpose of weight loss reduction or smoking cessation, including smoking cessation patches and prescription drugs used in the treatment of smoking cessation.

28. Charges resulting from an injury or illness related to the engagement of or in the practice or preparation of any hazardous activity, including but not limited to, handling explosives such as fireworks, the use of a motorized vehicle in any racing, speed, pulling or pushing, demolition or stunting activity, sky diving, bungee jumping, zip line riding, competitive skateboarding, competitive inline-skating, competitive mountain climbing, competitive bicycling, competitive water skiing, competitive snow skiing or competitive snowboarding.

29. Charges for preparing claim forms.

30. Charges by a Christian Science Practitioner, nurse or facility.

31. Tax charges, including but not limited to sales tax.

32. Charges prescribed by a court of law as a result of, but not limited to a DWI and/or DUI conviction

33. Charges related to an injury incurred as a result of war, declared or undeclared, including armed aggression.

34. Charges for massage therapy, except therapy performed by a chiropractor or physical therapist consistent with this Plan.

35. To the extent your failure or omission prevents the payment (in whole or in part) of any benefits covered by the Plan by another entity (including utilization or coordination of benefits and any waivers that you sign), this Plan will coordinate with the other entity's coverage as if the health benefit were otherwise eligible for coverage from the entity.

36. Charges arising out of a motor vehicle accident if a valid motor vehicle insurance policy is not in effect.

37. Any cost, expenses, or financial allocation from the Fund for medical or related services arising out of, caused, contributed to, or connected, directly or indirectly, to any exclusion and/or limitation provided in this Article.

38. Services for maintenance care, including but not limited to treatments which are non-rehabilitative or treatments for chronic pain.

39. Nursing Home charges.

40. Any cost, expenses, or financial allocation from the Fund for medical or related services arising out of, caused, contributed to, or connected, directly or indirectly, to any exclusion and/or limitation provided in this Article.

THE FOLLOWING BENEFITS ARE NOT ELIGIBLE FOR COVERAGE FROM THE FUND, BUT MAY BE REIMBURSED THROUGH THE HEALTH REIMBURSEMENT ARRANGEMENT, PROVIDED ALL THE OTHE REQUIREMENTS OF THIS SPD ARE SATISFIED.

1. Expenses that this Fund does not consider to be reasonable or customary, including, but not limited to telephone consultations, except through the Fund's telemedicine program.

2. Charges that are greater than the reasonable and customary charges.

3. Charges for anything considered custodial care, domiciliary care, or rest care as provided in a covered Skilled Nursing Facility.

4. Charges incurred by you related to self-inflicted sickness or injury, unless such injury or sickness is a result of a medically diagnosed condition such as depression.

5. Services for treatment leading to or in connection with transsexual surgery.

6. Charges for laser eye surgery including but not limited to Radial Keratotomy.

7. Services or supplies not specifically listed as covered by the Plan, provided that reimbursement will only be made from the HRA for those expenses permitted to be reimbursed by applicable law.

8. Services for or related to In Vitro Fertilization and Artificial Insemination.

PART E RETIREE BUY-IN PLANS

Articles XV through XVII describes the Retiree Buy-In Plans offered by the Upstate New York Engineers Health Fund. Each Retiree Buy-In Plan has its own eligibility requirements as described below.

A participant who has other health insurance coverage (either individual or group) is not eligible to participate in any of the Retiree Buy-In Plans. However, a participant who declined, or was not eligible to participate at the initial offering because they are enrolled in other health insurance coverage and subsequently loses their other health insurance coverage involuntarily may participate in the applicable Retiree Buy-In Plan so long as they meet the eligibility requirements and enroll in the Plan within 30 days from the date the other health insurance coverage was involuntarily terminated and provides a termination notice and an explanation of termination from the other health insurance. Any person who is (i) eligible to participate in, and is not enrolled in, other health insurance coverage (either group or individual); (ii) does not enroll in the Plan at the initial offering; and/or (iii) subsequently discontinues participation in the Plan, will not be permitted to later participate in any of the Retiree Buy-In Plans.

At the time a participant retires and elects not to participate in the Retiree Buy-In Insurance Plan and enrolls in another health plan that meets the minimum essential coverage requirement of the Affordable Care Act, the participant may elect to terminate any normal eligibility remaining after his/her retirement date and receive an allocation into his/her HRA account of an amount equal to $500.00 for each month of normal eligibility remaining, up to a maximum of 12 months (the "Voluntary Retiree Buy-Out Option."). Retirees who elect the Voluntary Retiree Buy-Out Option are permanently prohibited from participation in any of the Retiree Buy-In Plans.
Because monthly Retiree Buy-In premiums are deducted from the monthly pension benefits you receive from the Upstate New York Engineers Pension Plan, (if applicable), a written notice of discontinuance must be sent to the Upstate New York Engineers Pension Plan.

With the exception of the prescription drug co-pay amounts as described in Article X and dental benefits, the coverage under the Early Retirement Buy-In Plan and the Normal Retirement Buy-In Plan is the same coverage as the regular coverage provided by the Plan for active participants. Benefits under the Disability Retirement Buy-In Plan are the same as the Early and Normal Buy-In Plans until the participant qualifies for Medicare. See Article XVII for details.

PLEASE NOTE: There are special pre-certification requirements and claim procedures for the Retiree Buy-In participants with regard to in-patient hospital stays and out-patient surgeries, which require you to pre-certify with Aetna. Please see Part D "BENEFITS", pages 23 - 24.

The monthly premium for each of the Retiree Buy-In Plans is determined by the Board of Trustees and is subject to change.

To the extent permitted by applicable law, Early and Normal Retirement Buy-In Plan coverage ends upon your becoming eligible for Medicare. Special rules apply to participants when they become eligible for Medicare due to their disability. Your spouse may also participate in the applicable Retiree Buy-In Plan until your spouse becomes eligible for Medicare. Your spouse and/or dependent children are not permitted to participate in any of the Retiree Buy-In Plans if your spouse and/or dependent children were not eligible to participate at the time the Retiree Buy-In Plan was offered to you. Your eligible dependent children may participate in the Retiree Buy-In

Plans until both you and your participating eligible spouse become eligible for Medicare. You and your eligible spouse are required to notify the Fund Office if either of you become eligible for Medicare before attaining the age of 65 while participating in any of the Retiree Buy-In Plans.

ARTICLE XV – EARLY RETIREMENT BUY - IN PLAN

Eligible participants who elect to retire between the ages of 55 and 61 may participate in the Early Retirement Buy-In Plan if they meet the following requirement.

REQUIREMENTS

1. (a) The participant must be a participant of the Upstate New York Engineers Health Plan with a minimum of 4,000 hours during the five (5) Employment Years included in the Computation Period in which the number of hours contributed for the participant were greatest. For purposes of this determination, an "Employment Year" is the 12-month period ending on the last day of the month before the participant retired. The "Computation Period" is the seven (7) Employment Years immediately preceding the participant's retirement; and

(b) The participant must have accrued at least fifteen (15) years of Future Vesting Service under the Upstate New York Engineers Pension Fund and his or her benefit from the Upstate New York Engineers Pension Fund must never have been, or subsequently be, suspended due to work in Prohibited Employment under the Pension Plan.

ARTICLE XVI – NORMAL RETIREMENT BUY - IN PLAN

Eligible Participants who elect to retire between the ages of 62 and 65 may participate in the Normal Retirement Buy-In Plan if they meet the following requirements:

REQUIREMENTS

1. (a) The participant must be a participant of the Upstate New York Engineers Health Plan with a minimum of 4,000 hours during the five (5) Employment Years included in the Computation Period in which the number of hours contributed for the participant were greatest. For purposes of this determination, an "Employment Year" is the 12 month period ending on the last day of the month before the participant retired. The "Computation Period" is the seven (7) Employment Years immediately preceding the participant's retirement; and

(b) The participant must have accrued at least fifteen (15) years of Vesting Service under the Upstate New York Engineers Pension Plan and his or her benefit from the Upstate New York Engineers Pension Fund must have never been, or subsequently be, suspended due to work in Prohibited Employment under the Pension Plan.

2. The participant is a member of a group that participated in the Upstate New York Engineers Health Plan and not the Upstate New York Engineers Pension Fund, retired on or after attaining the age of 62; was eligible for benefits from this Plan at the time of retirement and had completed a minimum of at least fifteen (15) years of continuous eligibility in this Plan prior to retirement.

NOTE: Premiums must be received at the Fund Office on or before the first day of the month in which coverage is being purchased for.

ARTICLE XVII – DISABILITY RETIREMENT BUY - IN PLAN

To become eligible to participate in the Disability Retirement Buy-In Plan, the retiree must meet the following requirements:

REQUIREMENTS

1. Must be receiving a Disability Pension from the Upstate New York Engineers Pension Fund and his or her benefit from the Upstate New York Engineers Pension Fund must never have been or subsequently be suspended due to work in Prohibited Employment under the Pension Plan; and

2. Must have been eligible for coverage from this Plan at the time of the disability; and

3. The participant's employer(s) must have contributed to this Plan for a minimum of 4,000 hours during the five (5) Employment Years included in the Computation Period in which the number of hours contributed for the participant was greatest. For the purpose of this determination an "Employment Year" is the 12 month period ending on the last day of the month before the participant retired. The "Computation Period" is the seven (7) Employment Years immediately preceding the participant's retirement; and

4. The participant must have accrued at least fifteen (15) years of Vesting Service under the Upstate New York Engineers Pension Fund and his or her benefit from the Upstate New York Engineers Pension Fund must never have been, or subsequently be, suspended due to work in Prohibited Employment under the Pension Plan.

If you are an eligible retiree under the age of 65 with Medicare coverage, you must follow the procedures listed below when submitting claims:

1. Fill out a Claim Form, if applicable;

2. Include a copy of the itemized bill that was submitted to Medicare; and

3. Include a copy of the "Medicare Explanation of Benefits" or "Summary Notice" that corresponds to the itemized billing.

4. Note: If you are eligible for Medicare, you MUST enroll in Medicare in order to be eligible to participate in the Disability Retirement Buy-In Plan. If, at the time you are eligible to participate in the Disability Retirement Buy-In Plan, you are not yet eligible for Medicare, you MUST enroll in Medicare. If you elect not to enroll in Medicare then your participation in the Disability Retirement Buy-In Plan will cease.

NOTE: Notwithstanding the provisions of PART E "Retiree Buy-In Plans" the spouse of a disabled Retiree who opts out of the spousal health benefits will be allowed to opt into such benefits in the event the spouse involuntarily loses the health insurance that the spouse was receiving when he/she opted out, provided that the disabled retiree at all times continues to receive disability pension benefits from the Upstate New York Engineers Pension Fund.

ARTICLE XVIII – MEDICARE SUPPLEMENT PLAN

The Fund offers supplemental coverage to eligible Medicare participants. This Plan will reimburse the Medicare Part A and Part B deductibles and the 20% of the Medicare "approved charges"* that Medicare does not reimburse directly to the service providers.

*"Approved charges" include but are not limited to the lesser of the out-patient service charges or the Medicare's DRG (Diagnostic Related Group) charges.

ELIGIBILITY - Prior to attaining age 65, and if you meet the eligibility requirements, you will be notified and offered participation in this Plan. You must accept participation in this Plan at the initial offering in order to be eligible to participate, unless you are declining participation because you have other insurance coverage. In this case, you may participate in this Plan when your other insurance ceases, so long as your other insurance coverage ceases involuntarily, and you provide the Health Fund with a termination notice from the other plan.

On the first day of the month in which you attain age 65 you become eligible for Medicare. To the extent permitted by applicable law, your regular coverage with the Fund ceases and Medicare becomes your Primary insurance carrier.

All eligible retirees, spouses and widowed spouses who were participating in the Fund at the time they became eligible for Medicare are eligible to participate in the Medicare Supplement Plan.

A participant who is under the age of 65 and becomes eligible for Medicare may participate in the Medicare Supplement Plan so long as you were participating in one of the Fund's Health Plans at the time you became eligible for Medicare. However, you may elect to remain a participant in one of the Upstate New York Engineer Health Plans until you attain the age of 65.

COVERED BENEFITS

Medicare Part A deductible – The Plan will reimburse any Medicare Part A deductible that is incurred during a Medicare benefit period directly to the service provider.

Medicare Part A coinsurance – The Plan will reimburse the Medicare Part A coinsurance directly to the hospital or skilled nursing facility.

Medicare Part B deductible – The Plan will reimburse the Medicare Part B deductible for each benefit period directly to the service provider.

Medicare Part B 20% of approved charges – Medicare pays 80% of the established Medicare "approved charges*. The Plan will make payment directly to the service provider for the 20% portion of the Medicare Part B "approved charges"* that Medicare does not pay.

> *"Approved charges" include but are not limited to the lesser of the out-patient service charges or the Medicare DRG (Diagnostic Related Group) charges.

EXCLUSIONS - Any incurred costs that are not covered by Medicare Part A or B will not be covered by the Medicare Supplement Plan. This includes, but is not limited to:

1. Hearing Aid Claims

2. Charges in excess of the Medicare "approved charges"

3. Prescription Drugs*

*Prescription drugs or any portion of Medicare Part D benefits are excluded from payment or reimbursement under this Medicare Supplement Plan.

COST - The premium for the Medicare Supplement Plan is established by the Board of Trustees. The monthly premium must be deducted from the participant's monthly Upstate New York Engineers Pension Fund benefit, when applicable. Participants that are required to submit monthly premiums must submit their premium on or before the first day of the month for which coverage is being purchased.

CLAIMS FOR REIMBURSEMENT - When you become a participant under this Medicare Supplement Plan, you will be issued an I.D. Card. You will need to present this I.D. Card to your medical professional or health care facility that provides you with health care services. This gives them the necessary information for filing your claim with Medicare and this Plan. After Medicare has processed the claim, Medicare will forward you a "Medicare Summary Notice" regarding their payment and submit this same information to this Plan to process our portion of the claim. This Plan will then make payment directly to the service provider.

TERMINATION - You may terminate participation in this Plan at any time. You must notify the Upstate New York Engineers Health Fund, in writing, that you are terminating your participation in this Plan. Termination from this Plan is permanent and re-enrollment is prohibited.

ARTICLE XIX – MEDICARE SUPPLEMENTAL BENEFIT

You are entitled to this benefit if you meet the following eligibility requirements:

- You are a retiree that has been receiving a pension benefit from the Upstate New York Engineers Pension Fund for four (4) years,
- You are enrolled in Medicare because of your age, and
- You participated in the Fund pursuant to the terms of a collective bargaining agreement or participation agreement that specifically requires contributions for this Medicare Supplement Benefit and such contributions were actually received by the Fund on your behalf.

If you are eligible for this benefit, once your application is approved, you will receive an annual cash benefit equal to $599 each year. You will receive your first payment on the first July 1 or January 1 after you have been receiving a pension benefit for four years. For example, if your pension effective date with the Upstate New York Engineers Pension Fund was February 1, 2015, your first Medicare Supplemental Benefit payment will be made July 1, 2019.

This benefit will be paid each year as follows, unless otherwise terminated or modified by the Fund's Board of Trustees: (1) a payment of $300 on or about June 30th and (2) a payment of $299 on or about December 31st each year. If you are married at the time of your death, this benefit will continue to be paid each year to your surviving spouse, unless otherwise terminated or modified by the Fund's Board of Trustees.

This is not an accrued benefit. The Fund's Board of Trustees reserves the right to terminate or reduce this benefit at any time.

PART F GENERAL MATTERS

ARTICLE XX – CLAIMS INVOLVING THIRD PARTY LIABILITY

Note: This provision applies to all participants, spouses, dependent children, retirees, their spouses and their dependent children and beneficiaries with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms "you" and "your" refer to all participants, spouses, dependent children, retirees, their spouses and their dependent children and beneficiaries.

A. GENERAL - Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or otherwise responsible for your medical bills. The Trustees, in their discretion, may determine not to provide benefits under the Plan for you, if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to the participant. The rules in this Section govern how the Plan pays benefits, if at all, in such situations.

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

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant benefits it has advanced to you out of <u>any</u> recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

B. RIGHTS TO SUBROGATION AND REIMBURSEMENT - If you incur covered expenses for which a third party may be liable, you are required to notify the Health Fund Office of that fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

The Trustees may, in their sole discretion, require the execution of this Plan's subrogation agreement by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's Subrogation Agreement, no benefits will be provided unless you, your spouse (if any) and your attorney (if any) sign the form within 60 days of the date on which it is sent to you or your attorney. You must also notify the Plan before you retain another attorney or an additional attorney, since the attorney must also execute the lien form.

If a fully and properly completed Subrogation Agreement is not received by the Fund Office within the time period required under this Article, the Fund will not cover any charges or expenses that it reasonably believes are related to the illness or injury, even if you later execute the Subrogation Agreement. If you fail to properly execute a Subrogation Agreement and the Fund erroneously pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute an agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a

constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you and your dependent recover from a third party.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Article, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

You and/or your dependent are obligated to take all the necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's right under this Article. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. If you waive coverage or liability from a third party, the Fund will not cover any related expenses. If you or your dependent chooses not to pursue the liability, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you or your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

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

Any refusal by you and your dependents to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your dependent's behalf will be considered a breach of your contract with the Fund that the Fund provide to you the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependents affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of the limitations defense or preemption defense, to the maximum extent permitted by law.

In no event shall the failure of the Trustees to require execution of the Subrogation Agreement diminish or be considered a waiver of any refusal by you, your dependent or your attorney to allow the Fund a right to subrogation or the Plan's right of subrogation and reimbursement.

At the Plan's request, you must complete a form(s) that includes, but is not limited to the following information:

1. The details of your accident or injury;

2. The name and address of the person you claimed caused the accident or the injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Fund's Subrogation Agreement and return the signed Agreement to the Fund Office within sixty 60 days of the date the Subrogation Agreement was provided to you;

2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid but in no event more than sixty 60 days from the date the Subrogation Agreement was provided to you;

3. Provide the Fund Office with quarterly reports regarding the status of your third party claim or action including, but not limited to: motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to: motions, depositions, pretrial conferences, trial dates and settlement conferences; etc.

Your duty to provide this information to the Plan is a continuing one. The Fund will not cover any claims related to the accident if you and your attorney do not fully complete and return the Fund's Subrogation Agreement within 60 days of the date on which it is provided to you or your attorney.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you receive from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole." The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees have the right to disregard any findings, determinations, conclusions, or judgments regarding a third party action relating to your obligation to reimburse the Fund. The Trustees have the right to independently determine whether reimbursement is required and/or how the Fund receives the appropriate reimbursement or credit, including reduction of future benefits for you, your Spouse or dependents.

C. RIGHT OF FUTURE SUBROGATION AND REIMBURSEMENT - In addition to satisfaction of the existing lien from any recovery received, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

"Net Proceeds" shall be defined as the amount of your total recovery and/or judgment less payment of the Fund's lien, and your attorney's fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries that were subject of the third party action and that would have otherwise been covered by the Plan until the amount of said proceeds is exhausted.

It is only at the point that your future related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

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

You will be personally liable to the Plan for reimbursement owed to the Plan as well as for the Plan's attorneys' fees and costs incurred in recovering that amount from you, and we will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;

2. You fail to assign your claim against the third party to this Plan when required to do so;

3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;

4. You fail to require any attorney, including any subsequent retained attorney, to sign the Plan's Subrogation Agreement;

5. You and/or your attorney fail to reimburse the Plan all amounts owed determined in the Trustees' sole and absolute discretion;

6. You fail to provide the Plan with medical or other information to obtain the necessary information; or

7. You or your attorney fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries or, if necessary take legal action against you. The Plan may also recover the amount you owe from your Health Reimbursement Account. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's effort to recover the entire amount of the lien. The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with "Overpayments and Mistaken Payments".

The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

ARTICLE XXI – APPEAL PROCEDURE

CLAIMS PROCEDURE

Initial Decisions

Timeframes

Hospital Benefit, Major Medical Benefit, Prescription Drug Benefit, Doctor's Office Benefit, Home Health Care Benefit, Mental and Nervous or Substance Use Disorder Benefit, Other Covered Services Benefits, Miscellaneous Benefits, Dental Benefits and Vision Benefits.

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

Post-Service Claims: For claims not requiring pre-approval, e.g.., Post-Service Claims, you will be notified by the Plan of any adverse benefit determination within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the Plan notified you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of notice to prove it. For Surprises Services, a decision on a post-service claim will be made within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

Pre-Service Claims: The receipt of some medical benefits (Hospital Benefits, Home Health Care Benefits, Mental and Nervous Disorder Benefits, Substance Use Disorder Benefits, Durable Medical Equipment Benefits, and Elective Surgical Procedures performed in hospitals, ambulatory surgery centers, or physicians' offices) may be conditioned on advance approval from the Plan. Claims for such benefits are considered Pre-Service Claims, as defined above. For Pre-Service Claims, the following rules apply. Generally you will be notified of the Plan's determination (whether adverse or not), within a reasonable period, but no later than 15 days after receipt of the claim. The 15-day period may be extended up to an additional 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the Plan expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension

will describe the required information and the claimant will have 45 days from the receipt of the notice to provide the specified information. If the claim is improperly filed, the Plan will provide notice of the failure and the proper filing procedure within 5 days.
The rules are slightly different for Pre-Service Claims involving urgent care, i.e., Urgent Care Claims. For such claims, you will be notified by the Plan regarding the benefit determination (whether adverse or not) as soon as possible, but no later than 72 hours after receipt, unless you fail to provide information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but no later than 24 hours after the receipt of the claim, of the specific information needed to complete the claim. Notification of the decision of that claim will be provided within 48 hours after the Plan's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

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

Self Insured Death and Dismemberment Benefits

If your claim for Self Insured Death and/or Dismemberment Benefit is denied in whole or in part for any reason, then within 90 days after this Plan receives your claim, this Plan will send you written notice of its decision, unless special circumstances require an extension, in which case the Plan will send you written notice of the decision no later than 180 days after the Plan receives your claim. If any extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period and the date by which the Plan expects to render the benefit determination.

Dental Benefits

If your claim for dental benefits is denied in whole or in part for any reason, then Delta Dental will send you written notice of its decision in accordance with its policies and procedures. For appeals of adverse benefit determinations concerning your Delta Dental benefits, you should contact Delta Dental as described in Article XI of this Summary Plan Description.

Vision Benefits

If your claim for vision benefits is denied in whole or in part for any reason you should contact the Fund Office. For appeals of adverse benefit determinations concerning your vision benefit you should contact the Fund Office. The Fund will apply the same procedures as applied to the medical benefits.

Content of Notification of Initial Adverse Benefit Determination

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

1. The specific reason for the adverse determination;

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

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

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

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

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

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

<u>Appeals of Adverse Benefit Determinations</u>

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

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the initial adverse benefit determination of a Hospital Benefit, Major Medical Benefit, Prescription Drug Benefit, Doctor's Office Benefit, Home Health Care Benefit, Mental and Nervous Disorder Benefit, Substance Use Disorder Benefit, Other Covered Services Benefits, Miscellaneous Benefits, Dental or Vision Benefits. You must write to the Trustees within 180 days after you receive this Plan's initial determination. To appeal an adverse benefit determination of a Self-Insured Death and/or Dismemberment Benefit, you must write to the Trustees within 60 days after you receive this Plan's initial adverse benefit determination.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) should include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT

DETERMINATION WAS DATED _______________, 20_____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do no want to communicate about your situation unless they are sure he or she is your chosen representative.

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

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

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

Determination on Appeal

Time Frames

Pre-Service Claims for Benefits: The Plan will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the request for review (except that if the Plan provides two (2) levels of appeal, the decision has to be made within 15 days at each level).

Pre-Service Claims for Benefits Involving Urgent Care (i.e. Urgent Care Claims): The Plan will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Benefits: The Plan will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after receipt of the request for review (except that if the Plan provides two (2) levels of appeal, the decision has to be made within 30 days at each level).

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

Content of Adverse Benefit Determination on Review

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

1. The specific reason for the adverse benefit determination;

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

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to your claim for benefits;

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

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

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

External Review.

If you disagree with a determination made by the Plan related to a Surprise Service and you have followed the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an Independent Review Organization (IRO). External review is limited to claims for Surprise Services. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed within four months after you receive notice of the denial of your appeal (or, if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review must be filed with the Fund Office.

<u>Preliminary Review</u>. Within five business days of receiving your request for an external review, the Fund Office will complete a preliminary review of your request to determine whether it is

eligible for external review (e.g., whether you have exhausted the Plan's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) why it is not eligible, and you will receive contact information for the Employee Benefits Security Administration of the Department of Labor if you have any follow-up. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period, or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

Referral to an IRO. If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within 10 business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days. If you choose to submit such information, within one business day the assigned IRO will forward the information to the Fund Office. Upon receipt of any such information, your claim that is subject to external review may be reconsidered by the Trustees. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Trustees decide upon completion of their reconsideration to reverse their denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

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

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- a general description of the claim and the reason for the external review request;
- the date the IRO received the external review assignment and the date of the IRO's decision;
- reference to the evidence considered in reaching the IRO's decision;
- a discussion of the principal reason(s) for the IRO's decision, and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- a statement that judicial review may be available to you; and
- contact information for any applicable consumer assistance office.

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

Reversal of the Plan's Decision. If the IRO issues a final decision that reverses the Plan's decision, the Plan will pay the claim.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan.
If you disagree with the Trustees' final decision, you may file legal action to challenge that decision. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Any lawsuit against the Fund or its Trustees must be commenced in either the Northern District or Western District federal courts in the state of New York.

TIME LIMIT FOR LEGAL ACTION - The Trustees' decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled.

CAUTION: - The Trustees, the Summary Plan Description, and written information from the personnel at the Fund Office are the only authorized sources of Plan information to you. The Trustees have not empowered anyone else to speak for them with regard to this Plan. No employer, Local Union, Business Agent or Representative, Supervisor or Shop Steward is in a position to discuss your rights under the Plan with authority.

The above procedures apply for claims involving the Hospital Benefit, Major Medical Benefit, Prescription Drug Benefit, Doctor's Office Benefit, Home Health Care Benefit, Mental and Nervous Disorder Benefit, Substance Use Disorder Benefit, Other Covered Services Benefits, Miscellaneous Benefits, Dental Benefit (claims filed on or after July 1, 2013) and Death and Dismemberment Benefit (claims filed on or after January 1, 2013).

ARTICLE XXII – PLAN INTERPRETATIONS, DETERMINATIONS, AND AMENDMENTS

The Board of Trustees and/or its designees are responsible for interpreting this Plan and for making determinations under this Plan. In order to carry out this responsibility, the Trustees have the exclusive authority and discretion to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to interpret all of this Booklet's provisions, to interpret the provisions of the Trust Agreement governing the operation of this Plan; to interpret all of the provisions of any other document or instrument involving or impacting the Plan; and, to interpret all of the terms used in this Booklet and in all of the previously mentioned agreements, documents and instruments.

All such determinations and interpretations made by the Trustees, or their designees, will be final and binding upon any individual claiming benefits under the Plan and upon all participants and eligible dependents, all Employers, the Local Unions, any party who has executed any agreement with the Trustees or the Union, will be given deference in all courts of law, to the greatest extent allowed by applicable law; and, will not be overturned or set aside by any court of law unless the

court finds that the Trustees, or their designees, abuse their discretion in making such determinations or rendering such interpretations.

LOSS OF BENEFITS: Under certain circumstances permitted by applicable law, you may lose all or part of your benefits from this Plan. The Board of Trustees reserves the right to change the terms of this Plan, to change or terminate any and all benefits provided by this Plan, and terminate part or all of the Plan itself. Your entitlement to any benefits associated with loss service could cause you to lose benefits described in this SPD. If any detail regarding your participation under the Plan has been misstated, or a clerical error occurs, which causes a greater benefit to be paid to you than that to which you are entitled, an adjustment in your benefits will be made, based upon the facts. If you are judged guilty of causing a loss in Plan assets, you may, under certain circumstances, forfeit all or part of your benefits. If you have questions about how you may lose benefits under this Plan, please contact the Fund Office.

NOTE: No benefit in this Plan is "vested" in any participant, active or retired and can be terminated or modified at any time. Entitlement to coverage for any benefit in the future will depend upon the judgment of the Trustees in the future. **Benefits under this Plan will be paid only if the Trustees decide in their discretion that you are entitled to them.**

ARTICLE XXIII – MISCELLANEOUS

A. TIME LIMITATION FOR CLAIMS SUBMISSION - Except for HRA reimbursements, there is a one (1) year time limit for submission of claims to the Health Fund Office. All claims must be received by the Fund within twelve (12) months after the later of the date of service for the expense or the earliest date of entitlement of the benefit.

B. RECOVERY OF OVERPAYMENT AND MISTAKEN PAYMENTS - The Fund has a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund, and such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependents consent and agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits. In accordance with that constructive trust, lien and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

The Fund may recover overpaid benefits by offsetting all future benefits otherwise payable by the Fund on your behalf or on the behalf of your dependents. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you and your dependents. If the overpayment or advancement was made to your dependent, the Fund may offset the future benefits payable by the Fund to you and your dependents.

If you, or if applicable, your dependent or beneficiary, fail to reimburse the Fund and the Fund is required to pursue legal action against you or your dependent or beneficiary to obtain repayment of the benefits advanced by the Fund, you or your dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed to the Fund or the enforcement of any of the Fund's rights to reimbursement. You and your dependent or beneficiary also are required to pay interest at a rate determined by the Trustees from time to time from the date you became obligated to repay the Fund through the date that the Fund is paid in full amount owed.

By accepting benefits for the Fund, you agree to waive any applicable statute of limitations defense available regarding the enforcement of any of the Fund's rights to recoup overpayments.
Any refusal by you or your dependents to reimburse the Fund for an overpaid amount will be considered a breach of your contract with the Fund that the Fund provide to you with the benefits available under the Plan and you will comply with the rules of the Fund. Further by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the maximum extent permitted by law. The Fund has a right to file suit against you in any state or federal court that has the jurisdiction over the Fund's claim.

C. COOPERATION - Every participant must furnish to the Trustees all such information as may be reasonably requested by them for the purpose of establishing, maintaining and administering this Plan. The failure on the part of the participant to comply with such request in good faith will be sufficient grounds for delaying or denying payment of benefits. The Trustees will be the sole judges of the standard of proof required in any case, and they may from time to time adopt such methods and procedures as considered advisable.
For example, in order to process a claim under this Plan, it may be necessary for this Plan to obtain your medical and/or dental records. Every person covered under this Plan gives permission to this Plan to obtain your medical and/or dental records from any provider, nurse, physician, hospital, nursing home, skilled nursing facility, or other health care personnel or institution.

D. PAYMENT ON BEHALF OF THE INCOMPETENT - In the event a payment would be made by the Plan to a person determined by the Trustees to be incompetent, the Plan reserves the right to make such payment directly to the service provider or to another person or persons selected by the Plan to receive the payment on behalf of the incompetent person.

21123563v1

Upstate NY Engineers
101 Intrepid Lane
Syracuse, NY 13205

Presorted STD
US Postage Paid
Syracuse NY
Permit No 4238