# PAINTERS DISTRICT COUNCIL NO. 4
# HEALTH & WELFARE FUND
# SUMMARY PLAN DESCRIPTION

**Effective December 1, 2014**

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## Introduction

The Board of Trustees of the Painters District Council No. 4 Health & Welfare Fund is pleased to present this revised Summary Plan Description, which describes the benefits and eligibility requirements of the Welfare Plan. Also included in this booklet are the procedures that you should follow when filing a claim, and certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in this booklet are the result of continuous efforts of the Board of Trustees to offer an excellent program of benefits that will help meet the needs of your entire family. We urge you to read this booklet carefully so that you understand the complete package of benefits available to you and your eligible family members. You should share this booklet with your family and keep it in a convenient place for future reference.

The Welfare Plan is designed to help you and your family to meet the continuing rising costs of medical care as well as provide a measure of protection if you are unable to work due to layoff or disability.

This booklet summarizes the key features of your Welfare Fund benefits program. Complete details of the program are also contained in the other official Plan documents, including the Trust Agreement, the Fund's contracts with its benefit insurers and health maintenance organizations, and collective bargaining agreements, which legally govern the operation of the program. All official Plan documents are available for your inspection at the Fund Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

This booklet is not a contract of employment – it neither guarantees employment or continued employment with your employer or any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

If you have question about the plan or how to apply for benefits, do not hesitate to contact the Fund Office.

Sincerely,

Board of Trustees

# I
# DEFINITIONS

Certain terms used in this Summary Plan Description have special meanings. These terms will be capitalized and will have the meaning set forth below:

1.1 Certificate of Coverage. The term "Certificate of Coverage" will mean the document provided to you by the insurance company or HMO chosen by the Trustees to provide health and hospitalization coverage. Its purpose is to explain the provisions of the Group Contract.

1.2 Change in Family Status. The term "Change in Family Status" will mean your marriage or divorce, the death of your spouse, the termination of employment of your spouse, or such other change in your spouse's employment status that results in a termination or significant reduction in your health care benefits.

1.3 Code. The term "Code" will mean the Internal Revenue Code of 1986, as amended.

1.4 Collective Bargaining Agreement. The term "Collective Bargaining Agreement" will mean any agreement between the Union and an Employer, which agreement requires the payment of periodic contributions to the Fund or other written participation or other agreement acceptable to the Trustees, which agreement requires the payment of periodic contributions to the Fund.

1.5 Group Contract. The term "Group Contract" will mean the insurance contract used by the Trustees to provide health and hospitalization coverage benefits.

1.6 Contributions. The term "Contributions" will mean those payments made to the Fund as required by the Collective Bargaining Agreement reduced by the hourly administrative fee as established by the Trustees. Presently, the administrative fee is five per cent of the payments required by the Collective Bargaining Agreement.

1.7 Covered Employment. The term "Covered Employment" will mean employment of a type covered by a Collective Bargaining Agreement and requiring contributions to the Fund.

1.8 Dependent. The term "Dependent" means your spouse and each of your children under age 26, including legally adopted children and children placed with you for adoption to the extent required by law. Coverage for adopted children and children placed with your for adoption shall be provided on the same basis as coverage for your natural children. This Plan will also provide benefits pursuant to the terms of any "Qualified Medical Child Support Order," as defined in Section 609 of ERISA (including a National Medical Child Support Notice), as a result of any domestic relations matter.

1.9 Disability. The term "Disability" will mean a physical or mental condition resulting from bodily injury, disease or mental condition which renders a person incapable of continuing any gainful occupation and which entitles him to benefits under the New York State

Disability Benefits Law or Worker's Compensation Act. Disability shall be determined by the Trustees in their sole and absolute discretion.

1.10 Employee. The term "Employee" will mean any person employed by an Employer and covered by a Collective Bargaining Agreement.

1.11 Employer. The term "Employer" will mean (i) any one of the employer members of an employer association that enters into a Collective Bargaining Agreement with the Union; (ii) an independent signatory to a Collective Bargaining Agreement that is acceptable to the Board of Trustees; (iii) the Painters District Council No. 4 Security Benefit Fund; and (iv) the Union.

1.12 Fund. The term "Fund" will mean the **Painters District Council No. 4 Health & Welfare Fund**, which includes all contributions to the Trustees pursuant to the terms set forth in the Collective Bargaining Agreement, together with all the income, earnings and profits thereon received by the Trustees, less any expenses paid therefrom. The Fund may be used only for the purposes set forth in the Trust Agreement.

1.13 Fund Administrator. The term "Fund Administrator" will mean the person designated by the Trustees to handle certain of their day-to-day administrative duties.

1.14 Hour of Service. The term "Hour of Service" will mean each hour for which you are entitled to payment by the Employer and for which the Employer makes Contributions to the Fund pursuant to its obligation under the Collective Bargaining Agreement.

1.15 Minimum Balance. The term "Minimum Balance" will mean the minimum amount that must be in an individual's Health Care Account in order to be eligible for benefits. The Minimum Balance is an amount equal to six months of Monthly Premium for the lowest cost single coverage available under the Plan.

1.16 Monthly Premium. The term "Monthly Premium," will mean the amount determined by the Trustees to be the cost of a month of coverage for insured health benefits provided under the Plan.

1.17 Plan. The term "Plan" will mean the written plan of benefits of the Fund adopted by the Trustees setting forth the eligibility rules for the health and welfare benefits to be paid from the Fund.

1.18 Plan Administrator. The term "Plan Administrator" will mean the Board of Trustees of the Fund. The Plan Administrator will administer the Plan, keep the Plan's records and has discretionary authority to construe the terms of the Plan and make determinations on questions which affect eligibility of benefits.

1.19 Plan Year. The term "Plan Year" will mean the twelve month period beginning on June 1 and continuing to the following May 31.

1.20 Retirees. The term "Retirees" will mean the persons who have retired from the bargaining unit of Employees covered by the Collective Bargaining Agreement and are receiving a pension from the International Brotherhood of Painters and Allied Trades Pension Fund.

1.21 Trust Agreement. The term "Trust Agreement" will mean the Agreement and Declaration of Trust, Painters District Council No. 4 Health & Welfare Fund, dated December 10, 1991, together with any amendments made thereto.

1.22 Trustees. The term "Trustees" will mean the Board of Trustees of the Fund.

1.23 Union. The term "Union" will mean District Council No. 4 of Buffalo and Vicinity, International Union of Painters and Allied Trades of America, AFL-CIO, and its successors and assigns.

## II
## GENERAL INFORMATION ABOUT THE FUND

This Section contains certain general information which you may need to know about the Fund.

### A. General Fund Information

The name of the Fund is the Painters District Council No. 4 Health & Welfare Fund.

The provisions of the Plan became effective on June 1, 1995, which is called the Effective Date of the Plan.

The Fund's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve-month period beginning June 1 and ending the following May 31.

### B. Plan Administrator

The Plan is sponsored by the Board of Trustees of the Painters District Council No. 4 Health & Welfare Fund. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund.

The employer identification number of the Plan Sponsor is 16-6070541. The Trustees have assigned plan number 501 to the Fund.

The following individuals currently comprise the Board of Trustees:

**Employer Trustees:**

**Joseph Knarr**
Madar Construction
970 Bullis Road
Elma, NY 14059

**John O'Hare**
Huber Construction
136 Taylor Drive
Depew, NY 14043

**Jeffrey D. Sturtz**
A.R. Pierrepont Company
154 Berkeley Street
Rochester, NY 14607

**John Lignos**
Amstar of WNY
825 Rein Road
Cheektowaga, NY 14225

**Union Trustees:**

**Mark Stevens**
District Council #4
585 Aero Drive
Cheektowaga, NY 14225

**Jeffrey Carroll**
Glaziers LU 660
585 Aero Drive
Cheektowaga, NY 14225

**James Creighton**
Local 150
49 Navarre Road
Rochester, NY 14621

**Robert Sinopoli**
IUPAT Local 677
39 Saginaw Drive, Ste. 16
Rochester, NY 14623

Responsibility for administration of health and hospital insurance claims has been delegated to the insurance company or health maintenance organization providing those benefits. Responsibility for administration of life insurance claims has been delegated to the insurance company providing that benefit.

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Fund or the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

## C. Fund Administrator Information

The Trustees have delegated certain day-to-day administrative duties to the Fund Administrator. The name and address of the current Fund Administrator is:

Ms. Cynthia Webster
Painters District Council No. 4
Health & Welfare Fund
585 Aero Drive
Cheektowaga, NY 14225

The Fund Administrator also keeps the records for the Fund. The Board of Trustees has authorized the Fund Administrator to respond in writing to any questions you may have about the Fund. As a courtesy, the Fund Administrator may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot be relied upon in a dispute concerning your benefits. If you have an important question, you should contact the Fund Administrator for a written response.

## D. Service of Legal Process

The name and address of the Fund's agent for service of legal process is:

Board of Trustees
Painters District Council No. 4
Health & Welfare Fund
585 Aero Drive
Cheektowaga, NY 14225

Legal process may be served on the Plan Administrator or any individual Trustee.

## E. Type of Plan

The Plan is a welfare benefit plan providing health, hospitalization, health care reimbursement, supplemental unemployment, life insurance, disability, education, and vacation benefits. The health, hospitalization and life insurance benefits are insured through insurers or health maintenance organizations. Other benefits are provided on a self-insured basis.

The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries. In addition, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

## III
## PERSONAL ACCOUNTS

### A. Tax Free vs. Taxable Benefits

For purposes of determining your eligibility for benefits under the Plan, the Plan Administrator will create and maintain individual accounts on your behalf. A Health Care Account will provide you with tax-free medical benefits.

A Wage Replacement Account will provide you with taxable unemployment, disability, and vacation benefits.

The law prohibits the transfer of any balance in your TAX FREE accounts to your TAXABLE accounts and vice versa.

Each account will include a record of contributions received on your behalf, benefits paid, and fees and expenses charged against the account. The maintenance of these accounts is for record keeping purposes only. You do not have a vested right to the balance in the account or any benefit offered by the Plan; accounts are used only to determine your eligibility for benefits and actual segregation of assets does not occur.

**If there is no contribution to, or distribution from your Health Care Account or Wage Replacement Account for a period of twenty-four (24) consecutive months, then any balance in those accounts will be forfeited and added to the Fund' reserves. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible dependents), or upon the death of the survivor of your spouse or eligible dependents, will be forfeited and added to the Fund's reserves. Any balance remaining in your Wage Replacement Account will be forfeited upon your death and added to the Fund's reserves.**

### B. Allocation of Contributions

The basis on which Contributions made to the Fund on your behalf will be divided between your accounts will depend on the type of coverage, if any, you are receiving from the Fund. Contributions will be credited to your accounts as of the first of the month following the month they are received by the Trustees.

You will automatically be enrolled in single coverage from the Fund unless you choose family or two-person coverage or unless you provide a written certification that you have health care coverage through your Spouse or parent. Until your Health Care Account reaches the required Minimum Balance, the only benefit that you may receive is single health insurance coverage through the Fund for yourself.

The Minimum Balance ("MB") will be 6 months' of premiums for the lowest cost single health insurance coverage.

Thereafter, your Contributions will be allocated between Fund accounts according to the percentages set forth in the following table:

| | | **If your Health Care Account balance is:** | |
|---|---|---|---|
| | | Up to MB | Over MB * |
| **and your coverage from the Plan is:** | Outside Coverage | 100% Health | 20% Health |
| | Single | 100% Health | 50% Health |
| | Two Person (Local 660) | 100% Health | 80% Health |
| | Family | 100% Health | 97% Health** |

* The maximum amount that may be accumulated in your Wage Replacement Account is $12,500. Once your Wage Replacement Account equals or exceeds $12,500, all Contributions made to the Fund on your behalf, after reduction for administrative expenses, shall be allocated to your Health Care Account. When the balance in your Wage Replacement Account falls below $12,500, Contributions will again be allocated in accordance with the table above.

**The administrative fee is 3% of employer contributions. This amount is deducted from contributions to your Wage Replacement Account.

## IV
## HEALTH AND RELATED BENEFITS

### A. Health and Hospitalization Coverage

Health and hospitalization coverage will be provided through a health maintenance organization (HMO) or through a Group Contract issued by an insurance company, both of which shall be selected by the Plan Administrator.

In order to be entitled to health and hospitalization coverage, you must satisfy the following conditions:

(a) You must be working in Covered Employment or have reported to the Union as eligible to work in Covered Employment;

(b) You must have accumulated the Minimum Balance in your account to pay the Monthly Premium to the Fund Administrator on or before the 1st day of the month; and

(c) You must complete the necessary enrollment forms as provided by the Fund Administrator.

On your enrollment form, you may elect to enroll your spouse and/or eligible dependent children. Upon enrollment and from time to time thereafter, the Fund Administrator (or any insurer or HMO providing coverage) may require that you present satisfactory (as determined by the Fund Administrator, in its sole and absolute discretion) proof of the initial and/or continuing eligibility of your spouse or dependent children.

If you meet all the requirements for health and hospitalization coverage other than completion of the necessary enrollment forms, you will be enrolled in the lowest cost single coverage available.

**Special Enrollment Rights.** If you decline health and hospitalization coverage from the Fund for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

A child is considered placed for adoption on the date you first become legally obligated to provide support for the child whom you plan to adopt. If the adoption does not become final, coverage for the child will terminate as of the date you no longer have a legal obligation to support the child.

**1. Benefits**. The Group Contract of the insurance company whose product is then being used will control in defining the specific health and hospitalization benefits to which you and your Dependents are entitled including any deductibles, co-payments, lifetime or annual caps, network providers, and any other conditions or limitations on benefits. You will be provided a detailed description of your benefits directly from the insurance company and you may obtain additional copies, free of charge, from the Fund office.

**2. Disability**. In the event you incur a Disability, you will be entitled to continued health and hospitalization coverage without charge to your Health Care Account for as long as you are disabled, but not in excess of 26 weeks for each disability, provided you meet the Credit Hours requirement set forth below for the insurance quarter in which your Disability began. You will continue to receive the same form of coverage (i.e., single or family), under the same Group Contract or HMO, as you were receiving immediately prior to your disability.

| Eligibility Quarter | Insurance Quarter |
|---|---|
| February, March, April | June, July, August |
| May, June, July | September, October, November |
| August, September, October | December, January, February |
| November, December, January | March, April, May |

To meet the Credit Hours requirement you must accumulate:

(a) Two Hundred Seventy-Five (275) Hours of Service in an Eligibility Quarter;

(b) Five Hundred (500) Hours of Service in two (2) consecutive Eligibility Quarters;

(c) Seven Hundred (700) Hours of Service in the three (3) consecutive Eligibility Quarters; and

(d) Eight Hundred (800) Hours of Service in the four (4) consecutive Eligibility Quarters.

**3. Termination of Eligibility.** If at any time your Health Account is reduced to an amount less than one Monthly Premium, the Fund Administrator will notify you. At that time you may elect self-payment to maintain your health and hospitalization coverage benefit. You must make your payment prior to the beginning of the month for which you elected self-payment. Terms and conditions, as well as the amount required for self-payment, may be obtained from the Fund Office.

If you fail to make the initial payment for health insurance on a self-payment basis, you may still be able to exercise your rights to extend your health insurance coverage under COBRA as set forth in Article IX, below, but the length of your continuation coverage will be limited to the time periods specified. You should review the time limits set forth in Article IX for making a COBRA election.

Unless you are entitled to continue coverage in accordance with Article IX, your health and hospital insurance benefits from the Fund will end on the last day of the month in which occurs the earlier of:

(a) Your Health Care Account balance falls below the Minimum Balance or would fall below the Minimum Balance if you paid the Monthly Premium, or you fail to remit the required Monthly Premium to the Fund Administrator; or

(b) You are no longer working nor are available for work in Covered Employment.

**4. Family and Medical Leave Act.** If you are eligible for, and are granted leave by your employer under the Family and Medical Leave Act of 1993, (the "FMLA"), you will be entitled to health and hospitalization insurance coverage under the plan throughout the duration of your leave without a reduction to your Health Care Account. You will receive the type of coverage (i.e. family or single) you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after your FMLA leave, entitlement has been exhausted or expires, your Health Care Account will be reduced by the costs to maintain health and hospitalization insurance coverage for the term of the leave, unless the reason you did not return is due to:

(a) a continuation, recurrence, or onset of a serious health condition, which entitles you to leave under the FMLA; or

(b) other circumstances beyond your control as defined in the FMLA and the regulations thereunder.

**5. Hospital Stays in Connection with Childbirth.** Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Fund or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

**6. Reconstructive Breast Surgery.** Although cosmetic surgery may be excluded from the health and hospitalization insurance coverage offered by the Fund (see the Certificate of Coverage for further information in that regard), in accordance with the requirements of a Federal law entitled, the Women's Health and Cancer Rights Act of 1998, if the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund will also provide benefits for certain reconstructive surgery. In particular, in such a case, the Fund will provide to a participant or beneficiary who is receiving (or presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and physical complications associated with all stages of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

This coverage will be subject to the annual deductible and coinsurance provisions applicable to other surgical procedures. In addition, to the extent permitted by applicable law, this coverage may also be subject to benefit maximums and co-payment provisions that may apply under the Group Insurance Contract. You should review carefully the provisions of the Certificate of Coverage regarding any such restrictions that may apply. If you have any questions regarding this coverage, please contact the Fund Administrator.

**B. Health Care Reimbursement**

1. **Eligibility**. You will be eligible for Health Care Reimbursement coverage under your Health Care Account only after you have accumulated the Minimum Balance and you are enrolled and participating under a group health insurance plan offered through the Fund, through your spouse's employer, or through your parent's employer. If you are enrolled in your spouse's or parent's plan, that plan must provide "Minimum Value." A health plan provides Minimum Value if the health plan's share of the total allowed cost of benefits is at least 60 percent (i.e., has an actuarial value of at least 60 percent). If you do not enroll in coverage through the Fund, you will be eligible to use your Health Care Account only if you present your enrollment card in your spouse's or parent's group health plan and provide a copy of that plan's Summary of Benefits and Coverage (SBC) indicating that it meets the Minimum Value standard.

Once you become eligible for coverage under this Health Care Reimbursement benefit, you may file a claim for a distribution for the reimbursement of any Qualified Medical Expenses. Distributions reduce your Health Care Account on a dollar for dollar basis.

2. **Qualified Medical Expenses.** Qualified Medical Expenses are those that are not eligible for reimbursement under any other plan or any other source, including another health reimbursement account or flexible spending account, and are medically necessary expenses that are incurred by you, your spouse, and your Dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code. You may include all medical, dental, and vision expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body that are not covered or not reimbursed by insurance or any other source. Expenses may also be to alleviate or prevent a physical defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health are not eligible for reimbursement. Medical expenses qualify for reimbursement based on when they are incurred and are considered incurred at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them.

For purposes of this Health Expense benefit only, Dependents include your spouse and any child of yours who will be under age 27 as of the end of the calendar year, provided your spouse and child are covered under your policy or your spouse's policy. For this purpose, a "child" is an individual who is your son, daughter, stepson, or stepdaughter, and includes a legally adopted individual, an individual lawfully placed with you for legal adoption, and a foster

child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

As provided in Article III, once your Health Care Account falls below the Minimum Balance, you may not use it for any purpose other than the payment of premiums for single coverage for yourself. You may, however, save any Qualified Medical Expenses incurred while you are enrolled in coverage for later reimbursement.

**3. Carryover of Health Care Account.** If any balance remains in your Health Care Account after all reimbursements have been made for a Plan Year, that balance will be carried over to reimburse you for Qualified Medical Expenses incurred during a subsequent Plan Year. You will remain eligible for the Health Expense benefit if you leave Covered Employment or retire, but only to the extent of the balance remaining in the Health Care Account.

The balance in your Health Care Account will be forfeited and added to the Fund's reserves at the end of a period of twenty-four (24) consecutive months in which there is no contribution to, or distribution from your Health Care Account. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible Dependents), or upon the death of the survivor of your spouse or eligible Dependents, will be forfeited and added to the Fund's reserves.

You will have the option each year at open enrollment, and upon your retirement or termination of employment, to **permanently** opt out of Health Account coverage. If you do so prior to retirement or termination of employment, the balance in your Health Account may only be used for the payment of group health insurance coverage through the Fund. If you opt out of Health Account coverage at retirement, or after a period of 12 months without any Employer Contributions, then your entire Health Account will be forfeited.

4. **Claims.** You may submit your claim for reimbursement by completing a claim form and providing one of the two types of acceptable documentation. First, you may submit a claim under a medical, dental or vision care plan, which covers the person for whom the medical expense was incurred. The insurer will issue you an Explanation of Benefits (EOB), and the EOB should be provided with your claim as documentation of an unreimbursed medical expense along with evidence that your payment has been made for the total amount you are requesting. Second, for unreimbursed medical expenses not documented by an EOB, you may provide the Fund Administrator with a receipt of the medical expense, which includes: name of the recipient of the service; date of the service (not the paid date); description of the service; cost of the service; and name, address, and Tax I.D. number of the provider, record that shows payments made by insurance or denial by insurance and evidence that payment has been made by the claimant.

5**. Claims Procedure**

If a claim for reimbursement under the Health Care Account is wholly or partially denied, claims will be administered in accordance with the claims procedure set forth in Article XIV of this Summary Plan Description.

# V
# INCOME REPLACEMENT AND RELATED BENEFITS

## A. Wage Replacement Account

### 1. Supplemental Unemployment Benefit

You may receive a weekly Supplemental Unemployment Benefit payable from your Wage Replacement Account if you satisfy the following conditions:

(a) You must be involuntarily laid off from a unit covered by the Collective Bargaining Agreement;

(b) You must present proof that you are entitled to New York State Unemployment; and

(c) You must not refuse to accept work as a painter that has been offered by the Union or by an Employer.

The amount of the weekly benefit will be $250 ($400 for the initial waiting week) for any week that you are unemployed.

If you fail to report on the date indicated on the notice to report for referral card, you will forfeit all future benefits until such time as you return to work and are again laid off by an Employer after satisfying the eligibility requirements set forth above. If you refuse employment which is offered to you, you forfeit the benefit for that week and will continue to forfeit benefits in any following week in which you refuse employment.

You may not receive this benefit if you have voluntarily terminated employment or retired.

### 2. Disability Benefits

You will be entitled to a weekly disability benefit payable from your Wage Replacement Account for each week you are unable to work due to a Disability entitling you to a New York disability or workers' compensation benefit. The amount of the benefit is $250 per week ($400 for initial waiting week), but in no event greater than the balance in your Account.

### 3. Vacation Benefits

You are entitled to up to 6 vacation weeks per Plan Year and 6 holidays per calendar year. The amount of the benefit shall be $1,200 per week and $300 per holiday but shall not exceed the balance of your Wage Replacement Account. Vacation and holiday benefits for Apprentices and Industrial Members shall be in the amount of $650 per week for vacation and $300 per holiday, up to the balance of your Wage Replacement Account.

The Trustees will presume that you are on vacation for any day you are not working for an Employer and for which you do not receive an Unemployment Benefit or Disability Benefit from the Fund. Any vacation or holiday benefit to which you are entitled, but for which you have not applied, shall be paid to you at the end of the Calendar Year.

## VI
## SUPPLEMENTAL UNEMPLOYMENT BENEFIT

Buffalo-area participants may receive a weekly Supplemental Unemployment Benefit payable from the reserves of the Fund upon completion of 1,000 hours of service during a Plan Year. Buffalo-area participants are those working out of a Local Union with a $1.05 hourly contribution required under their Collective Bargaining Agreement for this benefit.

You must satisfy the following conditions in order to be eligible for this benefit:

(a) You must be involuntarily laid off from a unit covered by the Collective Bargaining Agreement;

(b) You must present proof that you are entitled to New York State Unemployment; and

(c) You must not refuse to accept work as a painter that has been offered by the Union or by an Employer.

Upon satisfying these requirements, you will be entitled to a weekly benefit of $125.

For purposes of determining the benefit under this Article, Hours of Service will be measured on a Plan Year basis but shall be effective for the twelve-month period beginning on the next succeeding December 1. A maximum 26 weekly payments will be paid in one Plan Year.

## VII
## GROUP LIFE INSURANCE

If you complete 500 hours of service during an Eligibility Period, you will be eligible for a group term life insurance benefit paying a death benefit of $50,000 for the next succeeding Coverage Period. In addition, your spouse will be entitled to a group term life insurance benefit of $5,000 and your dependent children, $2,500. Retirees after June 1, 2003 with the Minimum Balance in their Health Care Account will remain eligible for group term life insurance coverage to age 65, provided they were eligible for such coverage at the time of their retirement.

You will remain eligible for coverage in a Coverage Period if you have completed 500 Hours of Service in the prior Eligibility Period.

For purposes of this Article VII, "Eligibility Period" shall mean the twelve month period beginning May 1 and ending on the following April 30, and "Coverage Period" shall mean the twelve month period beginning August 1 and ending on the following July 31.

For purposes of initial eligibility only, you will be entitled to the group life insurance benefit on the first of the month following the completion of 500 hours of service. Thereafter, you must maintain your eligibility as set forth above.

You must be working in Covered Employment, or eligible for work in Covered Employment, to be entitled to the group life benefit provided hereunder.

The group life policy will control in determining the dates of eligibility, the conditions which must be satisfied to become insured (if any), and the benefits and the circumstances under which insurance terminates.

## VIII
## AMENDMENT AND TERMINATION

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan and may result in the forfeiture of the balance of your accounts. Under no circumstances will any Plan benefit become vested or non-forfeitable at any time with respect to any Participant (active, inactive or retired) or beneficiary.

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a Collective Bargaining Agreement remaining in effect that provided for continued Employer Contributions to the Fund. Therefore, the Trustees reserve the right to terminate the Plan, in whole or in part, at any time.

## IX
## CONTINUATION COVERAGE

In 1986, a Federal Law was enacted (Public Law 99-272, Title X) — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") — requiring that most employers sponsoring group heath plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Plan.

Continuation coverage is available only in connection with health and hospitalization benefits. Continuation coverage is not available in connection with any other benefits described

in this booklet (e.g., life insurance, educational, wage replacement, vacation benefits, etc.) or any other benefits you may have been receiving prior to the date your coverage terminates.

***You should review the following information carefully and share it with your covered dependents. Please remember that COBRA rights are provided only as required by law. Your rights may change in the event that the COBRA law changes.***

### 1. When Are You Eligible for COBRA Coverage?

If you are employed by a Contributing Employer and are covered by the Plan, you have a right to choose continuation coverage if you lose your eligibility for group health coverage by virtue of your failure to maintain the Minimum Balance in your Health Care Account because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following four reasons:

(a) the death of your spouse;

(b) a termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with a Contributing Employer) that results in your spouse's failure to maintain the Minimum Balance in your spouse's Health Care Account;

(c) divorce or legal separation from your spouse; or

(d) your spouse becomes entitled to Medicare (Part A or Part B).

If you are the dependent child of an employee covered under the Plan, you have the right to choose continuation coverage if you lose group health coverage under the Plan for any of the five following reasons:

(a) the death of the employee-parent;

(b) the termination of the employee-parent's employment (for reasons other than gross misconduct) or a reduction in the employee-parent's hours of employment with a Contributing Employer) that results in a failure of the employee-parent to maintain the Minimum Balance in the Health Care Premium Account;

(c) parents' divorce or legal separation;

(d) the employee-parent becomes entitled to Medicare (Part A or Part B); or

(e) the dependent ceases to be an eligible dependent child under the terms of the Plan.

In addition, there may be a right to continuation coverage for certain eligible retirees and their spouses, surviving spouses and dependent children if a Title 11 bankruptcy proceeding is commenced with regard to the retiree's Contributing Employer. If this occurs, you should contact the Fund Office concerning your rights.

**2. What You Must Do to Obtain COBRA Coverage**

Under the law, the employee or family member has the responsibility to inform the Fund Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. You should contact the Fund Office of these events by use of the form provided for this purpose.

Your employer has the responsibility to notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement. (However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status.)

When the Fund Office is notified that a qualifying event has happened, the Fund Office will notify you and/or your spouse or dependent children of the right to choose continuation coverage and the manner in which to do so.

Under the law, if your (or your family member's) coverage will terminate because of an event described above, you (or your family members) must inform the Fund Office that you want continuation coverage within 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect continuation coverage. If you (or your family members) do not properly and timely choose continuation coverage, your group health insurance coverage under the Plan will end.

Under the law, you may have to pay all or part of the premium for your continuation coverage. During the initial 18 or 36-month period of continuation coverage, you will have to pay 102% of the applicable premium for your continuation coverage. However, during the

additional 11 months of continuation coverage for disability, the Plan may charge up to 150% of the applicable premium for such continuation coverage.

You will be required to make the first premium payment retroactive to the date your benefits ended under the Plan. Your first payment must be made within 45 days after you elected to continue coverage. All subsequent payments will be due on the first of each month for that month's coverage. You will be notified by the Fund Office if the monthly premium amount changes. If payment of amounts due is not timely made, continuation of coverage will cease as of the end of the last month for which you timely paid.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

Continuation coverage may be elected for some members of the family and not others. In addition, one or more eligible dependents may elect COBRA even if the employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event (except in certain cases of added dependents, see the following section). A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her. However, dependent children have an independent right to elect COBRA Continuation Coverage if the parent does not elect coverage for the child.

### 3. Acquiring a New Dependent(s) while Covered by COBRA

Qualified COBRA beneficiaries are entitled to exercise the same rights to enroll dependents under the Plan as are similarly situated active employees who have not had a qualifying event.

In addition, if you acquire a new dependent through marriage while you are enrolled in COBRA continuation coverage, you may add the spouse to your coverage for the balance of the COBRA period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for up to five months of COBRA coverage. You must notify the Plan within 30 days of acquiring the new spouse.

In addition, a child who is born to or placed for adoption with a covered employee during the period of the employee's continuation coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA continuation coverage under the Plan. You must notify the Fund Office within 30 days after you acquire a new dependent. Once the child is enrolled pursuant to the Plan's rules, he or she will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the birth or adoption).

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for any newly added spouse.

However, since newborn children or children newly placed for adoption are qualified beneficiaries in their own right, COBRA coverage can continue for such children of an employee until the end of the maximum COBRA coverage period if the required premiums are timely paid. Check with the Fund Office for more details on how long COBRA coverage can last for these children.

To enroll your new dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new dependent.

### 4. Benefits Under and the Duration of COBRA Coverage

| **Coverage may continue for:** | **If:** | **Maximum length of COBRA coverage:** |
|---|---|---|
| You and your eligible dependents | Your employment ends for any reason (except for gross misconduct) | Up to 18 months (29 months if you or your eligible dependent is disabled)* |
| You and your eligible dependents | You no longer meet the Fund's eligibility requirements due to insufficient covered hours | Up to 18 months (29 months if you or your eligible dependent is disabled)* |
| Your eligible dependents | You die | Up to 36 months |
| Your eligible dependents | You are divorced or legally separated | Up to 36 months |
| Your eligible dependents | You become eligible for Medicare | Up to 36 months |
| Your covered dependent children | Your covered dependent child no longer qualifies as an eligible dependent under the Plan | Up to 36 months |

* Coverage provided under a New York insurance policy may continue for 36 months.

***This chart provides basic information regarding COBRA continuation coverage. Important details regarding such coverage are set forth in this section.***

If you choose continuation coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated non-COBRA beneficiaries for the types of benefits for which COBRA coverage is available. If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months from the date of the initial qualifying event. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months from that time. These maximum COBRA periods may be extended or reduced as described below.

### 5. Extension of the COBRA Coverage Period

An 18-month period of continuation coverage may be extended for up to 11 months (up to 29 months in total) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the employee's termination, reduction in hours or within the first 60 days of continuation coverage (or, in the case of a newborn child or child newly placed for adoption, within 60 days of birth or placement for adoption) and if the Fund Office is timely notified within 60 days of such determination (and within the initial 18 month continuation coverage period).

This 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA continuation coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18 or 29 month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the time coverage would otherwise have terminated as a result of the initial qualifying event. This extended coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, it is available to children born to, adopted by or placed for adoption with you (the active employee) during the initial 18-month period of continuation coverage.

Subsequent termination of employment following reduction in hours of employment will not be treated as a second qualifying event. You should notify the Fund Office immediately if a second qualifying event occurs during your continuation coverage period.

### 6. Why Your COBRA Coverage May End Early

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18, 29 or 36 month period for <u>any</u> of the following five reasons:

(a) The Plan no longer provides group health coverage.

(b) The premium for your continuation coverage is not timely paid. In such case, your coverage will terminate as of the last day of the last period for which a contribution was timely paid.

(c) The individual first becomes covered, after electing COBRA coverage, under another group health plan (as an employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but it does not apply to the individual because he or she has been credited with prior creditable coverage for the duration of the exclusion or limitation period.

(d) The individual becomes entitled to Medicare Part A or Part B (provided that such entitlement occurs after the COBRA election).

(e) Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Fund Administrator within 30 days of any such final determination. In such case, coverage will end as of the month that begins at least 30 days following such determination.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

## X
## CERTIFICATES OF CREDITABLE COVERAGE

When your (and your covered dependents') coverage under the Plan ends, the Plan will issue a Certificate of Creditable Coverage to each individual or family member whose coverage under the Plan ends. The Certificate provides the documentation of prior coverage and/or waiting periods that you and/or your family may need to reduce pre-existing condition limitations when enrolling in a new employer-sponsored health plan.

The Plan must provide you with a Certificate:

- when you lose coverage under the Plan or COBRA continuation coverage terminates; or
- if requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

- if you and/or your family had up to 18 months of creditable coverage under the Plan;
- the coverage start date (along with any eligibility waiting period); and
- the coverage end date under the plan.

If, within 62 days after your coverage under the Plan ends, you and/or your eligible dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a preexisting limitation or limitation period that may apply under that Plan.

For a copy of your and/or your eligible dependent's Certificate of Coverage, contact the Fund Administrator.

## XI
## HIPAA PRIVACY PROVISIONS

### Introduction

Members of the Board have access to the individually identifiable health information of Fund participants for administrative functions of the Fund. When this health information is provided from the Fund to the Trustees, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Trustees' ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Article XI:

> *Protected Health Information.* Protected health information means information that is created or received by the Fund and relates to the past, present, or future physical or mental health or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.
>
> *Electronic Protected Health Information*. Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.
>
> .

The Trustees shall have access to PHI from the Fund only as permitted under this Article or as otherwise required or permitted by HIPAA.

### Provision of Protected Health Information to Trustees

#### 1. Permitted Disclosure of Enrollment/Disenrollment Information

The Fund (or a health insurance issuer or HMO with respect to the Fund) may disclose to the Trustees information on whether the individual is participating in the Fund, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Fund.

#### 2. Permitted Uses and Disclosures of Summary Health Information

The Fund (or a health insurance issuer or HMO with respect to the Fund) may disclose Summary Health Information to the Trustees, provided that the Trustees request the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Fund; or (2) modifying, amending, or terminating the Fund.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Trustee had provided health benefits under a Health Fund; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

**3. Permitted and Required Uses and Disclosure of Protected Health Information for Fund Administration Purposes**

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph 4 and obtaining written certification pursuant to paragraph 6, the Fund (or a health insurance issuer or HMO on behalf of the Fund) may disclose PHI and Electronic PHI to the Trustees, provided that the Trustees use or disclose such PHI only for Fund administration purposes. "Fund administration purposes" means administration functions performed by the Trustees on behalf of the Fund, such as quality assurance, claims processing, auditing, and monitoring. Fund administration functions do not include functions performed by the Trustees in connection with any other benefit or benefit Fund of the Trustees, and they do not include any employment-related functions.

Fund administration shall also include the filing of a claim with the Department of Health and Human Services ("HHS") under the retiree reinsurance program established pursuant to Section 1102 of the Patient Protection and Affordable Care Act. The Fund shall disclose to the Secretary of HHS, on behalf of the Trustees, at such time and in such manner specified by the Secretary in guidance, information, data, documents, and records necessary for the Trustees to comply with the requirements of the program.

Notwithstanding the provisions of this Article XI to the contrary, in no event shall the Trustees be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

**4. Conditions of Disclosure for Fund Administration Purposes**

Trustees agree that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Fund (or a health insurance issuer or HMO on behalf of the Fund), Trustees shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Fund agrees to the same restrictions and conditions that apply to the Trustees with respect to PHI;

- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Fund of the Trustees;

- report to the Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;

- make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with HIPAA's privacy requirements;

- if feasible, return or destroy all PHI received from the Fund that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which 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

- ensure that the adequate separation between Fund and Trustees (*i.e.*, the "firewall"), required in 45 CFR §405(f)(2)(iii), is satisfied.

The Trustees further agree that if they create, receive, maintain, or transmit any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and they will ensure that any agents (including subcontractors) to whom they provide such Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Trustees will report to the Fund any security incident of which they become aware.

**5. Adequate Separation Between Plan and Plan Sponsor.**

The Trustees shall allow Fund employees access to the PHI. No other persons shall have access to PHI. These employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Trustees for non-compliance pursuant to the Trustees' employee discipline and termination procedures.

The Trustees shall ensure that the provisions of this paragraph 6 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

**6. Certification of Trustees**

The Fund (or a health insurance issuer or HMO with respect to the Fund) shall disclose PHI to the Trustees only upon the receipt of a certification by the Trustees that the Fund has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Trustees agree to the conditions of disclosure set forth in paragraph 5 of this section.

## XII
## FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you are eligible for, and granted leave by your Employer, under the Family and Medical Leave Act of 1993 (FMLA), and you are otherwise eligible for health and hospitalization insurance coverage under this Plan, you shall be entitled to continue that coverage for the duration of the leave. You shall receive the type of coverage (i.e., family or single) you were receiving immediately prior to your leave. Your Employer agrees to certify to your eligibility for FMLA leave and shall provide the Trustees with such additional information as they may reasonably request to verify your eligibility for continued health coverage hereunder, including any medical certifications as may be requested by your Employer under the FMLA and regulations thereunder. FMLA allows up to twelve weeks of unpaid leave and requires your Employer to maintain health care coverage during that time.

**If you fail to return to work after your FMLA leave entitlement has been exhausted or expires, the Plan may request reimbursement for the cost of maintaining your insurance, unless the reason you do not return is due to:**

(a) The continuation, recurrence, or onset of a serious health condition, which would entitle you to leave under FMLA; or

(b) Other circumstances beyond your control.

## XIII

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

### A. Purpose

Congress enacted the Uniformed Services Employment and Reemployment Rights Act ("USERRA") on December 12, 1994. The purpose of USERRA is to encourage non-career service in the Uniformed Services, to provide for the prompt reemployment of persons who serve in the uniformed services and to prohibit discrimination against such persons.

### B. Definitions

The terms listed below have special meanings relevant to this section.

(i) **Service in the Uniformed Services.** The phrase "Services in the Uniformed Services" will mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

(ii) **Uniformed Services.** The term "Uniformed Services" will mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

### C. Health Care Coverage

In the event that you are absent from work due to Service in the Uniformed Services you will be entitled to continue your health care coverage for you, your spouse and your eligible Dependent's for the lesser of –

- 18 months beginning on the day your absence of employment begins;
- the day after you fail to notify your Employer of your intent to return to work; or
- the day after you fail to return to a position of employment.

### D. Premiums

If you choose to continue coverage for the length of your Service in the Uniformed Services you will be required to pay 102% of the full premium under the Plan. You will not be required to

pay such premium if your length of service is less than 31 days. For detailed information on premium amounts and application for such coverage, please contact the Fund Administrator.

### E. Notification of Intent to Return to Work

It is important that you notify your employer of your intent to return to work within specified time periods. The time periods and notification requirements are specified below:

| LENGTH OF SERVICE | NOTIFICATION REQUIREMENTS |
|---|---|
| 30 days or less | Notification must occur no later than the beginning of your first full, regularly scheduled workday. Under special circumstances this time period may be extended to as soon as possible after the expiration of eight (8) hours of your first full, regularly scheduled workday. |
| 31 days – 180 days | Notification must occur no later than 14 days after the completion of your length of service. Under special circumstances this time may be extended. |
| 181 days or more | Notification must occur no more than 90 days after the completion of your length of service. |

## XIV
## ADDITIONAL PLAN INFORMATION

### A. Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Pension and Welfare Benefit Administration.

- To obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description, you may submit a written

request to the Plan Administrator,. The administrator may make a reasonable charge for the copies.

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

- 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.

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

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance form the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should

pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

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

**B. Claims Process**

Claims for benefits that are insured (*e.g,*. health and hospitalization insurance, life insurance) will be reviewed in accordance with procedures contained in the insurance contracts. These procedures are set forth in the booklets provided by the insurance company. If you need an additional copy, you may obtain one free of charge from the Fund office.

All other general claims for non-insured benefits shall be made to the Fund Administrator in writing and shall set forth the basis of the claim and shall authorize the Fund Administrator to conduct such examinations as may be necessary to facilitate the payment of any benefits to which you may be entitled under the terms of the Plan.

Health claims are divided into four categories. Different time lines and processing apply to each category. Listed below is a brief description of each category and the timeline and processing rules that apply to each.

**Urgent Care Claim**

The term "Urgent Care Claim" means a claim for medical treatment or care, which, if denied could seriously jeopardize your health or life or your ability to regain maximum function, or, in the opinion of a physician who has knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.

The Fund Administrator will notify you of the determination (whether adverse or not) within 72 hours after receipt of your claim, provided there is sufficient information to make a determination. In such case the Fund Administrator will notify you of your failure to provide sufficient information within 24 hours after they receive your claim. You will have 48 hours from receipt of the notice to provide the information needed. The Fund Administrator will notify you of the determination no later then 48 hours after receipt of the required information or, if you fail to provide the required information, the end of the 48-hour period you were given to provide

such information. The Fund Administrator may orally notify you of the determination. If notification is provided orally, you will also receive written notification within 3 days after such oral notification.

**Pre-Service Claims**

The term "Pre-Service Claim" means any claim for benefits that is made prior to receiving medical care or treatment.

Examples of Pre-Service Claims are:

- A request for pre-approval under a utilization program;
- A request for prior authorization of a medical service, care or treatment; or
- A request for prior authorization to receive a higher percentage of the benefit (e.g. 80% of the cost of the pre-authorized service versus 50%).

The Fund Administrator will notify you of the determination (whether adverse or not) within 15 days after receipt of your claim. Under special circumstances this time frame may be extended one time for an additional 15-day period. In such case the Fund Administrator will notify you of the extension prior to the end of the initial 15-day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient information to make a determination, the Fund Administrator will notify you of your failure no later than 5 days after receipt of your claim. Such notification may be oral, unless you or your authorized representative request it in writing, and will specify all information needed to make a determination. You will have 45 days from the date you receive notification to provide the required information.

**Post-Service Claims**

The term "Post-Service Claim" means any thing other than a Pre-Service Claim.

Post-service claims may include any of the following determinations made after medical treatment is rendered:

- Whether a provided service was medically necessary;
- Whether the particular medical service or treatment was appropriately provided for under the plan (e.g. whether the primary care physician appropriately referred the claimant to the physician providing the service); and
- Whether the claimant is eligible for the particular medical service or treatment.

It is important to note that a post-service claim includes a claim that was initially a pre-service claim. (i.e., a subsequent denial or restriction of a pre-certified claim could be affected by this rule.)

If your Post-Service Claim is denied in whole or in part, the Fund Administrator will notify you in writing within 30 days after receipt of your claim. Under special circumstances this time may be extended for an additional 15 day period. The Fund Administrator will notify you of the extension in writing prior to the expiration of the initial 30 day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient information to make a determination, the notification will specify all required information. You will have 45 days from your receipt of the notification to provide such information.

**Concurrent Care Decisions**

In the event that the Plan has approved a benefit for ongoing care or treatment (Concurrent Care) and later notifies you that your benefits are going to be terminated or reduced (for reasons other than by Plan amendment or termination) the Plan will notify you of such adverse benefit determination prior to the reduction or termination of your benefit.

If you would like to extend the course of treatment you are receiving beyond the approved period of time or number of treatments, for claims involving urgent care, you may submit a claim to the Fund Administrator at least 24 hours prior to the expiration of the approved period of time or number of treatments. The Fund Administrator will make a determination as soon as possible but no later than 24 hours after receipt of your claim.

**Notification Requirements**

The Fund Administrator must notify you of the determination of your claim within the specified time limits mentioned above. With regard to all initial benefit claims such notification can be in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any material or information necessary for you to perfect the claim and an explanation of why such information is necessary;
- 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 Section 502(a) of the Act following an adverse benefit determination on review.

- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request; and

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

- If an adverse benefit determination concerning an urgent care claim, the Plan must include the expedited review process in the notice.

**Claim Appeal Procedures**

The following summarizes the procedures that will be utilized by the Plan if your claim for a particular benefit is denied, and you subsequently appeal that decision. As with the general claims procedures above, the timing and requirements vary depending on how the particular claim is categorized.

**Urgent Care**

Within 180 days after your claim is denied, you may request a review of your claim through oral or written communication to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments orally, in writing, through facsimile or other electronic means. The Trustees will review your appeal and will notify you of their determination within 72 hours after receipt of your appeal.

**Pre-Service Claims**

Within 180 days after your claim is denied, you may submit your claim for reconsideration to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the appeal and provide you with their determination no later than 30 days after receipt of your appeal.

**Post-Service Claims**

Within 180 days after denial, you or your authorized representative may submit a written request for reconsideration of your claim to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the claim and provide, as soon as possible but no later than the date of the first Board meeting following the date the Plan receives your request for review, a determination. If your request for review is filed within thirty (30) days prior to the date of such meeting a determination will be made no later than the date of the second Board meeting following the date the Trustees receive your request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the Fund Administrator will notify you in writing describing the special circumstances and the date by which a determination will be rendered. The determination will be made no later than the date of the third Board meeting following the date the Trustees receive your request for review. The Fund Administrator will notify you in writing of the Trustees determination as soon as possible but no later than five (5) days after the determination is made. In this response, the Trustees will explain the specific reason for the determination, with specific reference to the provisions of the Plan on which the decision is based.

**Concurrent Care Decisions**

In the event that your appeal is with regards to a concurrent care decision, you will follow the procedures listed above as they apply. For instance if you are appealing a claim concerning urgent care you would follow the appeals procedures for urgent care claims.

In rendering a determination of your appeal the Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine pertinent to your claim. Such health care professional will not have been involved in the determination of your initial claim for benefits. The Trustees will make their determination based in whole or in part on such health care professionals' medical judgment.

**Notification Requirements**

The Fund Administrator will notify you of the determination of your claim within the specified time limits mentioned above. With regards to all claims on appeal such notification can be in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to specific Plan provisions on which the benefit determination is based;
- Statement that you are entitled to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to your claim for benefits;

- Statement describing any voluntary appeals procedures offered by the plan, your right to obtain such information and your right to bring civil action under §502(a) of the Act;

- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request;

- If adverse benefit determination is based on a medical necessity or experimental treatment, the Plan must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

### D. Right to Reclaim Overpayment or to Offset

If this Fund has benefits in excess of the amount required under the terms of the Plan, then it may recover the overpayment from you and/or your Dependent(s), or any relevant person, company, or organization. In such a case, you and your Dependent(s) must sign any document which the Trustees determine is needed to help the Fund recover its over-payment and otherwise make good faith attempts to assist the Fund in such recovery. Additionally, if the payment is made to you or your Dependent (or on your behalf) in error, you or your Dependant must repay the amount of the erroneous payment to the Fund. If the Fund owes you or your Dependent a payment for other claims incurred, then it has the right to subtract the amount you or your Dependent owe it from any payment it owes you or your Dependent.

### E. Plan Interpretations, Determinations, and Amendments

No individual other than the Plan Administrator or its duly authorized designee(s) has any authority to interpret the Plan documents, including this Summary Plan Description or the official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

The Plan Administrator and its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement, any collective bargaining agreement or participation agreement, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Fund. Without limiting the generality of the foregoing, the Plan Administrator and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Plan;

- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;

- Process and approve or deny benefit claims; and

- Determine the standard of proof required in any case.

All determinations and interpretations made by the Plan Administrator and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan, and shall be given deference in all courts of law, to the greatest extent permissible by law.

### F. Third Party Liability Cases

**NOTE:** This provision applies to all Employees and Retirees and their covered Spouses and Dependents, with respect to all of the benefits provided under this Plan. For the purpose of this provision, the term "Claimant" refers to all Employees, Retirees, covered Spouses, and covered Dependents.

#### 1. General

Occasionally, a third party may be liable for a Claimant's medical expenses. This may occur when a third party is responsible for causing a Claimant's illness or injury or is otherwise responsible for the medical bills. The rules in this Section govern how this Plan pays benefits in such situations.

These rules have two purposes. First, the rules insure that the Claimant's benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to advance the Claimant's covered expenses until his dispute with the third party is resolved.

Second, the rules protect this Plan from paying the full expenses in situations where a third party is liable. Under these rules, once a settlement, judgment or agreement is reached or it is determined that a third party is liable in any way for the injuries giving rise to these expenses, the Plan must be reimbursed for the relevant benefits advanced to the Claimant out of <u>any</u> recovery whatsoever that he receives that is in any way related to the event which caused him to incur the medical expenses.

Reimbursement to the Plan shall take place regardless of whether the recovery is characterized as being for medical expenses for which benefits were paid. Any amounts received must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of the Claimant. Where the recovery is partial or incomplete, the Fund's right to reimbursement takes priority over the Claimant's right to recovery, regardless of whether the claimant has been made whole for his or her injuries or losses. Except to the extent required by law, the Fund's right to reimbursement is not reduced by any attorneys' fees, court costs or disbursements that a Claimant might incur in a recovery action. You and/or your attorney must notify and consult with the Fund Administrator before commencing any legal action or administrative proceeding that may relate to or involve any recovery of any payments of Plan benefits and must subsequently keep the Fund Administrator apprised in writing of the status of (and material developments with respect to) the third-party action. Additionally, you and/or your attorney agree that, prior to any settlement of the third-party matter, the Fund must consent to the terms of the settlement. Your attorney must agree that no attorney's fees, expenses or costs of any kind will reduce the Fund's lien in this matter.

**2. Rights of Subrogation and Reimbursement**

By law, the Plan automatically acquires any and all rights which the claimant may have against the third party. If the claimant incurs covered expenses for which a third party may be liable, he is required to advise the Plan of that fact.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on the Claimant's behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or any other payment that he obtains from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

No Plan Benefits will be advanced unless the Claimant (or his authorized representative if he is a minor or if he can not sign), and his attorney (if any) sign a lien form acceptable to the Plan Administrator, in its sole and absolute discretion. If litigation is commenced, the Claimant must give five (5) days' prior notice to the plan of any pretrial conference, and the Plan has the right to attend any such conference. The Claimant must also notify the Plan before he retains another attorney or an additional attorney since that attorney must also execute the form. IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORM DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

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

**3. Right of Future Subrogation and Reimbursement**

In addition to satisfaction of the existing lien from any recovery received by the participant, spouse and/or dependent, the Fund is also entitled to future credit for future related Plan expenses equal to the monies received by the participant, spouse and/or dependent. As

such, the participant, spouse and/or dependent must spend the net recovery on related plan expense until the amount of said net recovery is exhausted. It is only at that point that the participant's spouse's and/or dependent's claim for the related Plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund Office will determine the net monies available for future credit.

Under certain circumstances, the Trustees may decide that you should assign your entire claim against the third party to the Fund. If the Fund recovers from the third party any amount in excess if the benefits paid to you plus the expenses incurred in making the recovery, the excess will be paid to you.

If you have any questions, please contact the Administrator.

### G. No Liability for the Practice of Medicine

None of the Fund, the Plan, the Plan Administrator, the Fund Administrator nor any of their designees are engaged in the practice of medicine; nor does any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you or your Dependents by any health care provider; nor will any of them have any liability whatsoever for any loss or injury caused to you or your Dependents by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

### H. Facility of Payment

Every person receiving or claiming benefits through the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator (or its designee) determines that the covered person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the covered person has not provided the Fund Office with an address at which he or she can be located for payment, the Fund may pay any amount otherwise payable to such person to his spouse, relative or any other person or entity determined by the Plan Administrator (or its designee), in its sole and absolute discretion, to be equitably entitled thereto. Any such payment will discharge entirely the obligation of the Fund.