A Guide To Your Welfare Plan

Summary Plan Description and Plan Document Effective January 1, 2015

United Association Local No. 7

Welfare Plan C

Medicare Eligible Retired Building Trade and HVAC Members

United Association Local No. 7 Welfare Plan C, For Medicare Eligible Retired Building Trade & HVAC Members

18 Avis Drive, Latham, NY 12110 *Telephone: 518-785-3440*

January 1, 2015

Dear Participant:

This booklet is a description of the medical coverage for Retirees age 65 and over as part of United Association Local No. 7 Welfare Plan C, For Medicare Eligible Retired Building Trade and HVAC Members, as such coverage is in effect on January 1, 2015. The term "Pensioner" as it appears in this document refers to employees who have met the eligibility requirements for retiree coverage under the plan. This booklet has eight sections:

Section I.	Overview of Plan
Section II.	Eligibility Requirements
Section III.	Description Of Benefits
Section IV.	Coverage Options
Section V.	Claim And Appeal Procedures
Section VI.	Your Rights Under ERISA
Section VII.	Protected Health Information
Section VIII.	Technical Details

The Welfare Plan provides benefits to other participants and such benefits are described in separate summary plan descriptions.

The Plan is governed by a Board of Trustees of which half represent the Union and half represent the participating employers. Our role, as Trustees of the Welfare Plan, includes the responsibility for collecting contributions (which are required by an agreement between your former employer and Local 7 or between your former employer and the Trustees).

The Board of Trustees has the ultimate responsibility for the management of plan assets. In addition, the Board of Trustees has the sole power to amend the Plan. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an auditor, an attorney and one or more investment managers.

The daily operation of the Plan is maintained by the Fund Administrator, Robert W. Valenty. Mr. Valenty and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

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

Sincerely,

Board of Trustees United Association Local No. 7 Welfare Plan C, For Medicare Eligible Retired Building Trade and HVAC Members

Welfare Plan C

Medicare Eligible Retired Building Trade & HVAC Members

Important Notice

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. The Trustees have endeavored to make this booklet as accurate as possible. However, the terms of the insurance policies shall override the provisions of this booklet in the case of any conflict between this booklet and the provisions of the insurance policies. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever in their sole and absolute judgment conditions so warrant. This booklet describes the Plan as it exists on January 1, 2015.

Caution

This booklet, together with booklets prepared by United American Insurance Company which are incorporated herein by reference and the personnel at the Fund Office and the Fund Administrator are authorized sources of Plan information for you. The Trustees of the Plan have not empowered any one else to speak for them with regard to the Welfare Plan. No employer, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority.

Communications

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

No Guarantee Of Income Tax Consequences

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

Directory

BOARD OF TRUSTEES

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300 Chester Avenue
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Important Aspects

- **Familiarize yourself with the whole booklet.**
- **Application must be made for all benefits before you may be entitled to benefits.**
- **Make sure that the Fund Office is aware of all your dependents and your current address.**
- **Make sure your death benefit beneficiary designation is up to date.**
- **All claim forms must be completely filled in; incomplete forms will be returned.**

Plan Change Or Termination

The Trustees reserve the right to change or discontinue 1) the types and amounts of benefits under the Plan, and 2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility or account balances have already been accumulated.

Benefits provided by the Plan:

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

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

Upon any termination or liquidation of the Trust under which Plan assets are held, the Trustees shall turn over any surplus Fund moneys to any future Trust Fund or Welfare Fund that may be created consistent with the terms of the Trust associated with this Plan. If no such new Fund is created, then and in that event, the Trustees shall turn over any surplus Fund moneys to the **then existing eligible employees on a pro rata basis in accordance** with the ratio his or her contributions bear to the entire contributions for the twelve (12) month period immediately preceding the termination date of the Trust.

Modification Of Benefits & Eligibility Rules

For All Participating Pensioners and their Covered Dependents.

This Summary Plan Description includes information concerning the benefits provided by the Trustees to participating pensioners and their covered dependents. It also outlines the circumstances that can result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that a pensioner or dependent might otherwise reasonably expect a plan to provide.

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

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

Section I. Overview Of Plan

The United Association Local No. 7 Welfare Plan C For Medicare Eligible Retired Building Trade and HVAC Members is a retiree welfare plan for Medicare Eligible retirees. The plan is funded in part by direct pensioner contributions and in part by any remaining Employer Contributions accrued to a Pensioner's "Personal Account" plan. No employer welfare contributions are made to the Personal Account Plan after retirement.

Your account will be decreased by any benefit distribution made from it, or administration charges levied against each participant's account on an equitable basis, if, for instance, the investment yield on the Plan reserves is not sufficient to offset the costs of administration of the Plan.

You will continue as a participant as long as you continue to remit the required premium for your coverage, whether debited from your Welfare account or your pension payment. If you are self-paying to the Plan for your Insurance Benefit coverage or your Insurance Benefit coverage has otherwise been extended, you are still a participant.

If you should die while there is still a balance in your account, your surviving spouse and your dependent children may use it for their health care expenses. If you have no spouse or dependent children when you pass away your account will be forfeited.

In the following sections you will see what is required to become eligible for the benefits that exist in the Plan for you once you are a participant.

Section II. Eligibility Requirements

This Section describes the eligibility requirements for benefits that exist in the Plan.

A. PENSIONERS

If you are a pensioner under the United Association Local 7 Pension Plan (Local 7 Pension Plan), you may continue to be covered under this Plan for as long as your account lasts. Furthermore, when your account runs out, you and your eligible dependents may be eligible to continue coverage under the Insurance Benefit. To be eligible, you must satisfy each of the following requirements:

- When you retire with a Normal Pension under the Local 7 Pension Plan, you must have been eligible for coverage (other than COBRA) under the Insurance Benefit on the day immediately preceding the start of your pension. If you retire on a Disability Pension, you must have been eligible for coverage (including COBRA) under the Insurance Benefit on the day immediately preceding the start of your pension.

- You must have been continuously eligible for coverage under the Insurance Benefit during the five-year period immediately preceding the start of your pension under the Local 7 Pension Plan, or you must have been continuously eligible for coverage under the Insurance Benefit during your Early Retirement under the Local 7 Pension Plan.

- You must make the required monthly payment on time.

- You and your spouse must be enrolled in Medicare Parts A & B to continue coverage under this Plan. If you enroll in a Medicare Part D plan, other than the Medicare Part D Plan offered by this Plan, you will become ineligible for this Plan's prescription drug plan now and in the future.

The cost of pensioner benefits is shared between the Welfare Plan and the eligible pensioners. Monthly payments are required for all pensioner coverage. The amount of the monthly payment is determined by the Trustees and may change from time to time.

If you return to covered employment, your retiree welfare coverage will continue with no interruption as long as your required premium is paid. You will not be covered as an active employee, and you will not receive personal account allocations for hours worked.

B. ELIGIBLE CLASSES OF DEPENDENTS

The plan provides coverage for Dependents as long as the Pensioner remains covered under the Plan. Only dependents that are Medicare Eligible will be covered for the benefits described in this summary plan description. Dependents not Medicare Eligible will be covered according to the benefits described in the United Association Local No. 7 Welfare Plan A for Building Trade & HVAC Members summary plan description for active employees. You can contact the Fund Office for an updated copy of that summary plan description.

A Dependent is any one of the following persons:

(1) A covered Retiree's Spouse and children from birth up to the limiting age of 26 years.

The term "Spouse" shall mean the person recognized as the covered Retiree's husband or wife under the laws of the state where the covered Retiree lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural, adopted or children placed with a covered Retiree in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Retiree.

The phrase "child placed with a covered Retiree in anticipation of adoption" refers to a child whom the Retiree intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving relationship, including birth certificates, marriage certificate or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Retiree for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician or other Medical Doctor of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are **excluded** as Dependents: other individuals living in the covered Retiree's home, but who are not eligible as defined; the divorced former Spouse of the Retiree; any person who is on

active duty in any military service of any country; or any person who is covered under the United Association Local No. 7 Plan A or United Association Local No. 7 Plan B as an Employee.

If both mother and father are Pensioners, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of a Pensioner will become eligible for Dependent coverage on the first day that the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan. False or misrepresented eligibility information will cause both your coverage and your Dependent's coverage to be irrevocably terminated (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Marriage certificates and birth certificates are required in order to enroll spouses and dependents.

In the event of divorce or when a dependent is no longer eligible for coverage, it is your responsibility to notify the Plan Office immediately. If you fail to notify the Plan Office, you will be responsible for all claims paid for your ineligible spouse and or ineligible dependent.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Retiree's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

Section III. Description Of Benefits

This Section contains descriptions, eligibility requirements, and limitations of benefits available under the Plan.

A. SCHEDULE OF BENEFITS

The following table is intended to give you a quick reference to the benefits available under the United Association Local No. 7 Welfare Plan C. The medical benefits are fully-insured by United American Insurance Company, 3700 S. Stonebridge Drive, McKinney, TX 75070. The prescription drugs benefit is insured by United American Insurance Company. Dental benefits are self-funded and administered by Blue Shield of Northeastern New York. All other benefits are administered by the Fund Office. A detailed description of each benefit follows the table.

Type of Benefit	Persons Covered	Benefit
Medical	Medicare eligible Pensioners & dependents	Insured with United American Insurance Company.
Prescription Drug	Medicare eligible Pensioners & dependents	Insured with United American Insurance Company.
Dental	Optional for pensioners and their dependents	Basic and preventive services, administered by Blue Shield of Northeastern NY
Vision	Pensioners & dependents who are participating in the medical benefit	Up to $300 per Plan Year for prescription eyeglasses, contact lenses and examination
Hearing	Pensioners & dependents who are participating in the medical benefit	Up to $2,000 every five (5) years for hearing aid(s) and evaluation.
Asbestos Screening	Pensioners	Periodic Asbestos Screening
Life Insurance	Pensioners	$2,500 per pensioner
Accidental Death and Dismemberment	Pensioners	By schedule
Medicare Part B Premium Reimbursement	Pensioners	Reimbursement for Medicare Part B insurance premiums by the Fund
Personal Account Plan Benefits		
Health Expense Benefit	Pensioners & dependents	Reimbursement from your account for certain health care expenses

B. INSURANCE BENEFIT

The details regarding the different coverages under the Insurance Benefit are described in this section.

Each month charges for certain insurance coverages will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. If your account runs out, you will be permitted to self-pay your health care insurance charges.

1. Medical Benefits

The Medical benefits are guaranteed under a contract insured by United American Insurance Company.

2. Dental Benefit

Retired Members may elect Dental Coverage at an additional monthly cost, by completing a Retiree Dental Election Form. This election will be available only at the time of retirement. If a retiree opts out of the dental program, he or she will forfeit his or her dental coverage permanently. Dental benefits are self-insured and are administered by Blue Shield of Northeastern New York. The schedule of Dental Benefits follows this section.

3. Vision Benefit

If a Retired Member is participating in the medical benefit, each covered family member will be entitled to reimbursement for the cost of an eye exam, and one pair of prescription eyeglasses or contact lenses every year. The maximum amount of this Benefit is $300 every plan year (July 1 – June 30).

4. Hearing Benefit

If a Retired Member is participating in the medical benefit, each covered family member, you or each such covered family member will be entitled to reimbursement of up to $2,000 in any consecutive five (5) year period for expenses pertaining to preliminary tests and purchase of a hearing aid(s). There is no reimbursement for expenses related to loss, theft, repairs, service or batteries.

5. Asbestos Screening Benefit

Pensioners who wish to have the asbestos screening physical must obtain an exam voucher from the Plan Office which must be presented to the Plan's designated examination provider at the time of the exam.

The examination provider uses the following guidelines set forth by OSHA which are based on the age of the worker and the length of exposure to asbestos:

- Workers who are under 35 years with less than 10 years of service; test every 5 years;
- Workers who are 35 – 44 years with 10 years or more of service; test every 2 years; and

- Workers who are 45 years and older regardless of the length of service; test annually.

6. Prescription Drug Benefit

Your Prescription Drug Benefit is insured by United American Insurance Company. Please refer to the booklet provided by United American for a description of this Benefit. If you have not received the United American booklet, please contact the Fund Office.

a. Having Your Prescription Filled At A Pharmacy

You may use your identification card at any participating pharmacy. There are over 68,000 pharmacies in the United American/Caremark network where prescriptions will be honored. If you have questions regarding whether your pharmacy participates, please contact Labor First at 1-856-316-7226. Once the pharmacist has dispensed your medication you will be asked to pay the required co-insurance for each new or refill prescription received.

Your co-insurance per 30-day prescription is 20% for generic drugs and preferred brand name drugs and 20% for non-preferred brand name drugs. You can also obtain a 90-day supply of your prescription your retail pharmacy.

b. Having Your Prescription Filled Through Mail Order

The mail order program allows members to receive larger quantities of maintenance medication (such as: heart medication, blood pressure medication, diabetic medication, etc.) at a discounted rate.

You can obtain a 90-day supply of your prescription through Caremark, United American's mail order program. Typically mail order is less expensive as than retail pharmacies. To get order forms and information about filling your prescriptions by mail, contact Caremark directly at 1-866-412-9774.

Medicare Eligible Retired Building Trade & HVAC Members

SCHEDULE OF MEDICAL AND DENTAL BENEFITS

MEDICAL BENEFITS

Only benefits that are Medicare Eligible Expenses will be covered as medical benefits for Pensioners and Dependents under this Plan. The Schedule of Benefits provided by United American Insurance Company describes the benefits payable under this Plan. Note that the hearing and vision benefits are self-funded and administered through the Welfare Plan.

DENTAL BENEFITS

Calendar Year deductible,
per person $50

The deductible applies to these Classes of Service:

Class B Services - Basic

Class C Services - Major

Dental Percentage Payable

Class A Services -
Preventive & Diagnostic.....80%

Class B Services -
Basic.....80%

Class C Services -
Major 50%

Maximum Benefit Amount

Per person per
Calendar Year .....$1,000 for Class C -Major

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically or Dentally Necessary services or supplies that are covered under this Plan.

Covered Employer is an Employer participating in the Plan by virtue of being signatory to the Trust agreement.

Covered Person is an Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Enrollment Date is the first day of coverage.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Family Unit is the covered Retiree and the family members who are covered as Dependents under the Plan.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes, without limit, Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

As the insurer, United American has the discretionary authority to decide whether care or treatment is Medically Necessary based on policy requirements that it must be a Medicare covered service.

The Plan or Fund Administrator has the discretionary authority to decide whether care or treatment is Dentally Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Pensioner means a person who meets the eligibility provisions of Section II and is collecting a pension from the United Association Local 7 Pension Plan.

Plan means United Association Local No. 7 Welfare Plan, which is a benefits plan for certain qualified Retirees of Board of Trustees of United Association Local No. 7 Welfare Plan C, For Medicare Eligible Retired Building Trade and HVAC Members and is described in this document.

Plan Participant is any participating Pensioner or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

PLAN EXCLUSIONS

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, any charge that is not an eligible expense under Medicare Part A, Part B, or Part D is not payable under this Plan.

COORDINATION OF BENEFITS

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two or more health insurance contracts, plans or policies ("policy or policies") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service which would be covered by all the policies, we will coordinate benefit payments with any payment made under the other policies. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

    A. Any group remittance, group, or blanket insurance policy; including HMO and other prepaid group coverage; except that blanket school accident coverages or such policies

offered to substantially similar groups (e.g., Boy Scouts, Youth Groups) shall not be considered health insurance policy.

B. Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization or employee benefit organization.

C. Any Blue Cross, Blue Shield or other service type group plan or group remittance subscriber contract.

D. Any coverage under governmental programs, or any coverage required or provided by statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance polices; or

E. Medical benefits coverage in group and individual mandatory automobile traditional "fault" type contracts. On the insured Retiree Medical Plan (insuring those Medicare Eligible retirees) Medicare will be the primary plan, and the insured plan is secondary, as outlined in the policy.

2. **Rules to Determine Payment.** In order to determine which policy is primary certain rules have been established. The first of the rules listed below which applies shall determine which policy shall be primary:

A. If the other policy does not have a provision similar to this one, then it will be primary.

B. If you are covered under one policy as a retiree and you are only covered as a dependent under the other policy, the policy which covers you as a retiree will be primary.

C. Subject to the provisions in Paragraphs "1" and "2" below, if you are covered as a child under both policies, the policy of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the policy which covered the parent longer is primary.

1. If the other policy does not have the rules described immediately above, but instead has a rule based on gender of a parent and, as a result, the policies do not agree on which shall be primary, the policy under which you are the dependent of a male will be primary.

2. There are special rules for a child of separated or divorced parents. If your parents are separated or divorced, benefits are determined in this order:

- first, the policy of the parent with custody of the child;
- then, the policy of the spouse of the parent with custody of the child;
- finally, the policy of the parent not having custody of the child.

However, if the terms of a court decree state the order of responsibility and the entity obligated to pay or provide the benefits of the policy of that parent has actual knowledge of the court decree, that policy shall be primary.

D. If you are covered under one of the policies as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other policy, the policy covering you as an active employee will be primary. However, if the other policy does not have this rule in its coordination of benefits provision, and as a result this Plan and the other policy do not agree on which shall be primary, this rule shall be ignored.

E. If none of the above applies, then the policy which has covered you for the longest time will be primary.

The above rules apply whether or not you actually make claim under both policies.

3. **Payment of the Benefits When This Plan is Secondary.** When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other policy and under this Plan do not exceed the amount we would have paid if we were primary.

4. **Right To Receive and Release Necessary Information.** We have the right to release or obtain information, which we believe necessary to carry out the purpose of this section. We will not notify you or obtain your consent before releasing or obtaining information except as required by applicable Federal and State laws and regulations. We will not be legally responsible to you or any one else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments to Others.** We may make payment, in our sole discretion, to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid and they satisfy our obligation to you under this Plan.

6. **Our Right to Recover Overpayment.** In some cases, we may have made payment to you even though you had coverage under another policy. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits program if we have not already received payment from that other program. You must sign any document which we feel is needed to help us recover any overpayment.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the allowed amount made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each year.

(2) One bitewing x-ray series every 6 months.

(3) One full mouth x-ray every 36 months.

(4) One fluoride treatment for covered Dependent children under age 19 each Calendar Year.

(5) Emergency palliative treatment for pain.

(6) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 16, once per tooth in any 36 months.

Class B Services:
Basic Dental Procedures

(1) Amalgam restorations on primary or permanent teeth.

(2) Oral surgery. Routine extractions, soft tissue impaction, partial bony impaction, complete bony impaction, and fractures.

(3) Repair of dentures and bridges.

(4) Rebasing or relining of removable dentures.

(5) Endodontics (root canals).

(6) Extractions. This service includes local anesthesia and routine post-operative care.

(7) Recementing bridges, crowns or inlays.

(8) Fillings, other than gold.

(9) General anesthetics, upon demonstration of Medical Necessity.

Class C Services:
Major Dental Procedures

(1) Installation of crowns, not part of a bridge. Not more than once every 5 years.

(2) Installation of removable or fixed bridges to replace one or more natural teeth. Not more than once every 5 years.

(3) Installation of full or partial dentures. Not more than once every 5 years.

(4) Periodontics (gum treatments).

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for Class C - Major Dental Procedures, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Retiree fills out the Employee/Retiree section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

BlueShield of Northeastern New York
30 Century Hill Drive
Latham, New York 12110

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the allowed amount for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(6) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(7) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(8) **No listing.** Services which are not included in the list of covered dental services.

(9) **Orthodontia.** Orthodontic treatment and orthognathic surgery.

(10) **Personalization.** Personalization of dentures.

(11) **Replacement.** Replacement of lost or stolen appliances.

(12) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

7. Life Insurance Benefit

The Life Insurance Benefit provides a Death Benefit to your designated beneficiary if you die while a participant in this Plan. The amount is $2,500 for pensioners. This Benefit is self-funded by the UA Local No. 7 Welfare Plan.

8. Accidental Death & Dismemberment Benefit

This provides coverage for loss of a member as a result of an accident and such loss occurs within 90 days of the accident. A member means a hand, a foot, or loss of sight in one eye. The Accidental Death and Dismemberment Benefit is currently self-funded by the UA Local No. 7 Welfare Plan, and pays in accordance with the following schedule:

Loss	Pensioner Benefit
Life	$2,500
One member	$1,250
Two members	$2,500

No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

a. bodily or mental illness or disease of any kind;

b. medical or surgical treatment of an illness or disease;

c. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

d. suicide or attempted suicide;

e. intentional self-inflicted injury;

f. participation in, or the result of participation in a felony, or a riot;

g. war or act of war, declared or undeclared; or any act related to war, or insurrection;

h. service in the armed forces of any country while such country is engaged in war; or

i. police duty performed during service in the Armed Forces or units auxiliary thereto.

9. Medicare Part B Premium Reimbursement

Covered Pensioners are eligible to be reimbursed for all or part of their Medicare Part B insurance premiums. Each year the Fund will reimburse covered pensioners for the Medicare Part B premiums paid on their behalf during the prior Plan Year. Spouses, widows and dependents are not eligible for this reimbursement. The amount of reimbursement is at the discretion of the Trustees.

Example: Suppose you pay $1,156.80 in Part B insurance premiums on yourself for the year ending December 2011. Then in 2012 you may apply for reimbursement. In order to be reimbursed you must submit a copy of your 2011 Form SSA-1099 as proof of payment. Your reimbursement check will be processed as soon as we receive your Form SSA-1099.

C. PERSONAL ACCOUNT PLAN BENEFITS

The Personal Account Plan Benefits accrued while an Active participant are designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. The following Benefit may be reimbursed from any remaining funds in your Personal Account after retirement:

1. *Health Expense Benefit*

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

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

a. dental expenses,
b. eye care expenses,
c. hearing aids,
d. physical exams,
e. Insurance Benefit deductibles, co-insurance and co-payments, and
f. Prescription Drug deductibles, co-insurance and co-payments.

Claims under this Benefit may be submitted only if they total at least $200. You may add several bills together in order to reach the $200. In any event, regardless of the amount of your covered bills, in the months of March and November you may submit such bills to the Plan. Such submissions are not permitted in any other month.

Finally, claims for reimbursement under this Benefit must be made within twelve (12) months from the date the expense was paid.

D. BENEFIT LIMITATIONS

Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

Reimbursable expenses are not allowed to be withdrawn from your account if your account would be reduced below the amount of annual premium required for family coverage. This provision is necessary to provide a reserve for you for the most vital benefits of a Welfare Plan.

Your total reimbursements for the Health Expense Benefit may not exceed $10,000 in any one Plan Year (July 1—June 30).

E. TERMINATION OF BENEFITS

Welfare coverage will be permanently terminated for non-payment of required premium. Premiums are due on the first of the month for the month of coverage. A 15-day grace period is granted from the due date for payment of premiums. If payment is not received after 30-days from the date due (except where special circumstances exist as determined on a case-by-case basis) coverage will be terminated. Once retiree coverage is terminated, retiree coverage may not be reinstated for any reason at a later date.

Section IV. Coverage Options

Each month charges for certain insurance coverages will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. If your account runs out, you will be permitted to self-pay your health care insurance charges.

A. SINGLE COVERAGE

If your spouse and children are already covered under your spouse's employer's health care plan, you may elect to be covered for "single" health care insurance only.

B. EXEMPTION OF COVERAGE

If you are covered under your spouse's employer's health care plan or some other employer health care plan, you may elect to not be covered under the Medical Benefit of the Insurance Benefit.

Special Enrollment Rights

There are several circumstances under which you may qualify for a special enrollment period and enroll a Dependent who is not currently enrolled:

Gaining a Dependent

If you gain a new Dependent through marriage, birth, adoption, or placement for adoption, you may add your new dependent to the plan as long as you make the request not later than 30 days of the marriage, birth, adoption or placement for adoption.

If your Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage your dependent loses eligibility for such coverage, you may add your Dependent to the plan as long as you make the request not later than 60 days after the date of termination of such coverage.

If your Dependent becomes eligible for state premium assistance, you may add your Dependent to the plan, as long as you make the request not later than 60 days after the date your Dependent is determined to be eligible for such assistance.

C. COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

Spousal Eligibility for COBRA Coverage

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

1. Your death.

2. Divorce.

Dependent Eligibility for COBRA Coverage

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

1. Your death.

2. Divorce - of the child's parents.

3. The child ceases to qualify as an eligible Dependent.

Notifications to the Fund Office

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare.

You have the responsibility to inform the Plan Administrator in case of a divorce, a child's loss of status as an eligible dependent or the birth or adoption of a dependent. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Plan Administrator within the time limits may result in your ineligibility for COBRA continuation coverage.

Notification of COBRA Rights

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

Election of COBRA Coverage

The spouse and dependent children each has independent election rights. A pensioner may elect COBRA continuation coverage on behalf of his or her spouse, and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have at least 60

days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Plan Administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form is received by the Plan Administrator on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the Plan Administrator.

Benefits Provided Under COBRA Coverage

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance or disability income benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you eliminate or reduce such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Termination of COBRA Coverage (How Long Coverage Lasts)

COBRA coverage is generally available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The plan sponsor no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the plan sponsor) except for any period the other group health plan limits coverage of your pre-existing conditions.

4. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

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

Cost of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants described in the section on Continuation Coverage for Retirees.

Additional Information About COBRA Coverage

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

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

Section V. Claim & Appeal Procedure

A. CLAIM PROCEDURE

Insured Medical Benefits: Claims for Medical Benefits Insured by United American Insurance Company are sent to:

United American Insurance Company
PO Box 8080, McKinney, TX 75070
Telephone: 972-529-5085

Self-Insured Dental Benefits: Claims for Self-Insured Dental Benefits administered by Blue Shield of Northeastern New York, the third-party administrator (TPA), are to be sent to:

Blue Shield of Northeastern New York
30 Century Hill Drive
Latham, NY 12110
Telephone: (518) 220-4600 or (800) 483-7621
Out of area: (800) 810-2583
Website: www.bsneny.com

Most providers will submit the claims for you based on the information on your identification card. If you need to file a claim directly, claim forms can be obtained from the Fund Office:

UA Local 7 Welfare Fund
18 Avis Drive
Latham, NY 12110
Telephone: (518) 785-3440
Website: www.ualocal7.org

Pharmacy Benefits Insured by United American (PDP): You may obtain prescriptions at participating pharmacies by presenting your identification card and paying coinsurance, without submitting a paper claim. If it is necessary to purchase a prescription because you do not have your identification card or because the pharmacy where your prescription is filled is a non-participating pharmacy, you may submit your claim for reimbursement to the prescription benefits manager (PBM):

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136
1-866-412-9774

Self-Funded Self-Administered Vision, Hearing, Life Insurance, AD&D, Asbestos Screening, and Medicare Part B Reimbursement Benefits: Applications for these self administered benefits must be made in writing on forms that may be obtained from the Fund Office.

B. CLAIM DENIAL AND APPEAL

Initial Decisions

What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:
A request for a health care service, supply, item, or prescription drug that you think you should be able to get
A request for payment of a health care service, supply, item, or prescription drug you already got
A request to change the amount you must pay for a health care service, supply, item, or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of an item or service you think you still need.

If you decide to file an appeal, you can ask your doctor or other health care provider or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

How do I file an appeal?

1. Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing. Your MSN is the notice you get every 3 months that lists all the services billed to Medicare and tells you if Medicare paid for the services.
2. Circle the item(s) you disagree with on the MSN, and write an explanation of why you disagree with the decision on the MSN or on a separate piece of paper and attach it to the MSN.
3. Include your name, phone number, and Medicare number on the MSN and sign it. Keep a copy for your records.
4. Send the MSN, or a copy, to the company that handles bills for Medicare listed on the MSN. You can include any other additional information you have about your appeal. Or you can use CMS Form 20027, and file it with the Medicare contractor at the address listed on the notice. To view or print this form, visit www.cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.
5. You must file the appeal within 120 days of the date you get the MSN in the mail.

You'll generally get a decision from the Medicare contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

In some cases, you can file a fast appeal.

How do I ask for a fast appeal?

With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO), will decide if your services should continue.

Ask your doctor or other health care provider for any information that may help your case if you decide to file a fast appeal.

Call your QIO to request a fast appeal no later than the time shown on the notice you get from your provider. Use the phone number for your QIO listed on your notice to request your appeal.

If you miss the deadline, you still have appeal rights:

—If you have Original Medicare, call your QIO.

—If you're in a Medicare health plan, read your notice carefully and follow the instructions for filing an appeal with your plan. You can also call your plan.

Visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the phone number for the QIO in your state.

If you have a Medicare Prescription Drug Plan

You have the right to do all of the following (even before you buy a certain drug):

Get a written explanation (called a "coverage determination") from your Medicare drug plan. A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your benefits, including whether a certain drug is covered, whether you've met the requirements to get a requested drug, how much you pay for a drug, and whether to make an exception to a plan rule when you request it.

Ask for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your plan's formulary.

Ask for an exception if you or your prescriber believes that a coverage rule (like prior authorization) should be waived.

Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

How do I ask for a coverage determination?

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription, the pharmacist will give you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't give you this notice, ask for a copy.

You or your prescriber may make a standard request by phone or in writing, if you're asking for prescription drug benefits you haven't gotten yet. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why the exception should be approved.

How can I get help filing an appeal?

For more information about the different levels of appeals in a Medicare drug plan, visit www.medicare.gov/publications to view the booklet "Medicare Appeals." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. TTY users should call 1-877-486-2048.

You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP).

Appeals of Adverse Benefit Determinations

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

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Pre-Service, Urgent Care Medical or Dental, or Post-Service Medical or Dental Claim, you must appeal to the TPA, Blue Shield of Northeastern New York, Medicare or to the PBM, United American within 180 days after you receive the initial adverse benefit determination. To appeal an adverse determination of any other benefit you must write to the Trustees within 180 days after you receive the initial adverse benefit determination. Notwithstanding anything in this paragraph to the contrary, for Concurrent Care Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded only a reasonable period of time to appeal.

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

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

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

Appeals of Adverse Medicare Decisions

As United American will pay all claims approved by Medicare all appeals must go through Medicare. Members can make an appeal to Medicare on denials by visiting http://www.medicare.gov/claims-and-appeals/index.html within 120 days of receiving a Medicare Summary Notice. Here members can complete a Redetermination Request Form to appeal the payment of a claim.

Special Rule Regarding Urgent Care Claims

If urgent care claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the plan's benefit determination on review, shall be transmitted between you and the third-party administrator by telephone, facsimile, or other similarly expeditious method.

Determinations on Appeal

Time Frames

Pre-Service Claims: The third-party administrator will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review (except that if there are two (2) levels of appeal, the decision has to be made within 15 days at each level).

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

Life Insurance, Accidental Death and Dismemberment, and Disability Claims: Appeals of adverse Disability Benefit claims must be decided by the Trustees within 45 days (plus a

possible 45-day extension, if necessary). Appeals of adverse Life Insurance and Accidental Death and Dismemberment claims must be decided by the Trustees within 60 days (plus a possible 60-day extension, if necessary).

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

Content of Adverse Benefit Determination on Review

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

1. The specific reasons for the adverse benefit determination;

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

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

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

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

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

C. FUND OFFICE CLAIM PAYMENT POLICIES

It is the policy of the United Association Local No. 7 Welfare Plan C, For Medicare Eligible Retired Building Trade and HVAC Members to issue payments for all claims that are administered by the Fund Office within a period of 30 days from the date of receipt of the claim by the Fund Office.

For all claims, the following will be required:

- Obtain an appropriate claim form(s) from the Fund Office.

- Complete your portion of the form(s). Be sure that the participant's signature and the participant's social security number are in the proper spaces.

- Upon completion of the claim form(s), attach all itemized bills, insurance information, and proof of payment and return it to the Fund Office.

An expense is considered to be incurred on the date the service or treatment is paid or a purchase is made, rather than on the date the bill is received.

D. INCOMPETENCE

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

E. COOPERATION

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

F. CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error.

G. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all covered Retirees and their covered spouses and dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all pensioners, covered spouses and covered dependents.

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

These rules have two (2) purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant benefits it

has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

1. Rights Of Subrogation And Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all right, which you may have against the third party.

In addition to its subrogation right, the Plan has the right to be reimbursed for payments made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party, whether or not designated as payment for medical expenses, before any other expenses, including attorneys' fees, are taken out of the payment.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement.

2. Assignment Of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

3. Failure To Disclose And/Or Cooperate

If you fail to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and/or failure to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Plan for the reimbursement owed to this Plan by the third party. This Plan may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you.

H. THE TRUSTEES' DECISION IS FINAL AND BINDING

The Trustees' final decision with respect to their review of your appeal will be final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction. The Trustees have exclusive and absolute authority and discretion to determine all questions of

eligibility and entitlement to benefits under the plan as well as to make all interpretations of plan provisions. Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Section VI. Your Rights Under ERISA

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

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

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

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

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

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

  The Health Insurance Protection and Portability Act (HIPAA) requires that the health insurance issuer provide a Certificate of Creditable Coverage (HIPAA Certificate) to each individual who requests one so long as it is required while the individual is covered under the Plan or within 24 months after the individual's coverage under the plan ends. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new plan in which the individual enrolls to request a certificate of the individual's creditable coverage from the Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

  Requests for Certificates should be directed to the Fund Office of the UA Local No. 7 Welfare Plan,18 Avis Drive, Latham, NY 12110, 518-785-3440. Telephone requests are accepted only if

the Certificate is to be mailed to the address that the Plan has on file for the individual for whom the request relates. Other requests must be made in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- The last date that the individual was covered under the Plan;
- The name of the participant that enrolled the individual in the Plans; and
- A telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evident of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the Certificate.

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

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

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

- **Assistance with Your Questions.** If you have any questions about your plan, you should contact the fund administrator. If you have any questions about this statement or about your

rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor at:

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

or

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

200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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

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

Section VII. Protected Health Information

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

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

A. PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

1. Payment and Health Care Options

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

2. Payment

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

3. Health Care Operations

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

4. Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide

the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management.

5. Other Covered Entities

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

6. Plan Sponsor

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

B. POTENTIAL IMPACT OF STATE LAW

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

C. OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1. Required by Law

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

2. Public Health Activities

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

3. Health Oversight Activities

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

4. Abuse or Neglect

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

5. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

6. Law Enforcement

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

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

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by

law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donations and transplantation.

8. Research

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

9. To Prevent a Serious Threat to Health or Safety

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

10. Military Activity and National Security, Protective Services

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

11. Inmates

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

12. Workers' Compensation

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

13. Others Involved in Your Health Care

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

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

D. REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

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

2. Disclosures to You

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

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

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

E. OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

F. YOUR RIGHTS

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

1. Right to Request a Restriction

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

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

You may request a restriction by calling us at the number/writing to: *Robert W. Valenty, Fund Administrator, UA Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440.*

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

2. Right to Request Confidential Communications

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

You may request a restriction by calling/writing: *Robert W. Valenty, Fund Administrator, UA Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440*. It is important that you direct your request for confidential communications to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

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

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for

payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

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

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

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

3. Right to Inspect and Copy

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

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

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

You may request an electronic copy of our protected health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, as long as that request is clear, conspicuous and specific. Any change that is assessed to you for these copies, if any, will be reasonable and based on the cost to the Plan.

4. Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling/writing to *Robert W. Valenty, Fund Administrator, U.A. Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440*. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

5. Right of an Accounting

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

You may request an accounting by submitting your request in writing to *Robert W. Valenty, Fund Administrator, UA Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440*. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2004. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

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

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

G. COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us. A copy of the complaint form is available from this contact office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human

Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

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

Section VIII Technical Details

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

PLAN NAME: United Association Local No. 7 Welfare Plan C for Medicare Eligible Retired Building Trade & HVAC Members.

EDITION DATE: This Summary Plan Description is produced as of January 1, 2015.

PLAN SPONSOR: Board of Trustees of United Association Local No. 7 Welfare Plan.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 14-6029930

PLAN NUMBER: 501 (assigned by federal government)

TYPE OF PLAN: Medicare Eligible Retiree Only Welfare Benefit Plan

PLAN YEAR ENDS: May 31.

PLAN ADMINISTRATOR: Board of Trustees of United Association Local No. 7 Welfare Plan, 18 Avis Drive, Latham, New York, 12110, Phone # (518) 785-3440.

FUND ADMINISTRATOR: Robert W. Valenty, 18 Avis Drive, Latham, NY 12110. The daily operation of the Plan is maintained by the Fund Administrator, Robert W. Valenty.

AGENT FOR THE SERVICE OF LEGAL PROCESS: Mr. Robert Valenty, Fund Administrator, United Association Local No. 7 Welfare Plan, 18 Avis Drive, Latham, New York, 12110, Phone # (518) 785-3440.

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

TYPE OF PLAN ADMINISTRATION: Direct employees of the Board of Trustees.

TYPE OF FUNDING: Benefits are partially insured and partially self-insured.

To the extent medical and prescription drug benefits are insured, such benefits are guaranteed under contracts of insurance by United American Insurance Company.

PLAN BENEFITS PROVIDED BY: The United Association Local No. 7 Welfare Plan, United American Insurance Company (Medicare Supplement & PDP), and Blue Shield of Northeastern New York.

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

TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the United Association Local No. 7 Welfare Plan, Plan C for Medicare Eligible Retired Building Trade & HVAC Members. The following are the individual Trustees that make up the Board as of January 1, 2015:

Welfare Plan C

For Medicate Eligible Retired Building Trade & HVAC Members

Employer

Peter Campito
c/o Campito Plumbing & Heating
P.O. Box 550
Latham, NY 12110

Robert Snyder
c/o F.P.I. Mechanical, Inc.
11 Green Mountain Drive
Cohoes, NY 12047

Dan Keating
c/o Burniche Piping, Inc..
PO Box 311
Waterford, NY 12188

Union

Timothy J. Carter
9 Carrolls Grove Road
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