A Guide To Your Welfare Plan

Summary Plan Description and Plan Document Effective July 1, 2021

United Association Local No. 7

Welfare Plan C

Medicare Eligible Retired Building Trade and HVAC Members

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

July 1, 2021

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 July 1, 2021. 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 and an appendix as follows:

The Welfare Plan provides benefits to other (active) 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, Ryan Heimroth. Mr. Heimroth 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 July 1, 2021.

Caution

This booklet, together with booklets prepared by Humana and Labor First, 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 anyone 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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P.O. Box 2187
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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.

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 monthly 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 as long as required monthly premium payments are timely made.

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 back to the Plan.

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. It is your responsibility to enroll in Medicare Parts A & B. You can call the Social Security Administration for more information on enrolling in Medicare Parts A & B at (800) 772-1213. More information can also be found online at www.ssa.gov/benefits/medicare/.

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 briefly 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) However, if you work sufficient hours in covered employment to become eligible under Plan A (for active employees), you will be covered under Plan A (and subject to all terms of that Plan, including the active premium rates) until you lose eligibility, at which time, you can re-enroll in this Plan (as long as you request re-enrollment within 2 months of the loss of active coverage). Furthermore, you may only leave this Plan and later re-enroll in coverage if you have left to work in covered employment under the provision set forth in the previous sentence, or if you initially waive coverage because you are covered under a spouse's employer sponsored plan. Once you have lost coverage under a spouse's employer sponsored plan or under Plan A, you must request enrollment in this plan within 2 months of the loss of such coverage.

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 legal spouse under the laws of the jurisdiction where the marriage was performed, regardless of gender. 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, subject to the provisions of applicable law: 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 (subject to the requirements of the Uniformed Services Employment and Reemployment Rights Act

(USERRA)); 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, birth certificates, and Social Security cards 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 Fund Office immediately. If you fail to notify the Fund 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 titled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section titled 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 titled 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 and prescription drug benefits are fully-insured through a Medicare Advantage Plan with Humana, which is provided by Labor First. Labor First is available to assist with any questions you may have about the Humana Medicare Advantage program. Dental benefits are self-funded and administered through Delta Dental of New York (the third-party administrator - "TPA"). 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 Humana
Prescription Drug	Medicare eligible Pensioners & dependents	Insured with Humana
Dental	Optional for pensioners and their dependents	Basic and preventive services, administered by Delta Dental of New York
Vision	Pensioners & dependents who are participating in the medical benefit	Comprehensive vision benefits administered by NVA.
Hearing	Pensioners & dependents who are participating in the medical benefit	Up to $5,000 every five (5) years for hearing aid(s) and evaluation, effective July 1, 2021 ($2,000 prior to July 1, 2021).
Asbestos Screening	Pensioners	Periodic Asbestos Screening
Life Insurance	Covered Pensioners	$2,500 per pensioner
Accidental Death and Dismemberment	Covered Pensioners	By schedule
Medicare Part B Premium Reimbursement	Covered Pensioners	Reimbursement for Medicare Part B insurance premiums by the Fund (up to the standard Part B premium amount)
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, the premium will be deducted from your pension check, or you will be permitted to self-pay your health care insurance charges. If you are self-paying and a premium payment is missed, you will be removed from coverage.

Medical Benefits

The Medical benefits are insured under a Humana Medicare Advantage Plan provided by Labor First.

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 provided through the Delta Dental of New York network. The schedule of Dental Benefits follows this section.

Vision Benefit

As of July 1, 2021, the Plan has adopted the NVA Vision Benefit, which provides comprehensive vision benefits for Retired Members and their dependents who are participating in the Plan's medical benefit. The NVA Schedule of Vision Benefits is included as Appendix A of this Summary Plan Description. To locate a participating provider visit www.e-nva.com.

Effective January 1, 2022, the benefit plan year will be the calendar year (January 1 – December 31) for purposes of the NVA Vision Benefit. There will be a short benefit plan year in 2021 (July 1 – December 31). Thereafter, the limits for this benefit will re-set each January 1st.

Hearing Benefit

Effective July 1, 2021, 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 $5,000 in any consecutive five (5) year period for expenses pertaining to preliminary tests and purchase of a hearing aid(s) (prior to July 1, 2021, this limit was $2,000). There is no reimbursement for expenses related to loss, theft, repairs, service or batteries.

Asbestos Screening Benefit

Pensioners who wish to have the asbestos screening physical must obtain an exam voucher from the Fund 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.

Prescription Drug Benefit

Your Prescription Drug Benefit is insured under the Humana Medicare Advantage Plan provided by Labor First. Please refer to the booklet provided by Humana for a description of this Benefit. If you have not received the Humana booklet, please contact the Fund Office.

a. Having Your Prescription Filled At A Pharmacy

You may use your Humana identification card at any participating pharmacy. There are over 60,000 pharmacies in the Humana 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 and specialty drugs. You can obtain these prescriptions from your retail pharmacy. You can also obtain a 90-day supply of your generic drugs, preferred brand name drugs and non-preferred brand name drugs through your retail pharmacy or through the Humana mail order program discussed below. Specialty drugs are limited to a 1 month supply.

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 Humana'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 Humana directly at 1-888-457-4708.

SCHEDULE OF MEDICAL AND DENTAL BENEFITS

MEDICAL BENEFITS

Only benefits that are Medicare Eligible Expenses will be covered as medical benefits for Pensioners and Medicare eligible Dependents under this Plan. The Schedule of Benefits provided by Humana describes the benefits payable under this Plan. Note that the hearing and vision benefits are self-funded. The hearing benefit is administered through the Fund Office and the vision benefits are administered by NVA.

DENTAL BENEFITS

Calendar Year deductible,
per person $50

The deductible is waived for preventive and diagnostic care. 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

A. DEDUCTIBLE

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.

B. 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.

C. PARTICIPATING PROVIDERS

The Plan has negotiated special contracts with a network of area Physicians, Hospitals, and other health care providers known as a Preferred Provider Organization ("PPO"). These Participating Providers have agreed to accept the discounted amount the Plan pays for any covered services, plus any additional deductibles or coinsurance you are responsible for paying, as payment in full. Non-Participating Providers may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to the Covered Charge paid by the plan in a practice called balance billing.

When a Covered Person uses a Participating Provider, that Covered Person will receive a higher level of coverage from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Additional information about this option, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, and updated as needed. You can search for participating providers on Delta Dental's website at deltadentalins.com.

D. MAXIMUM BENEFIT AMOUNT

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

E. 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.

F. 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 coverage 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.

G. 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.

H. 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).

I. 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 Employee fills out the Employee 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:

Delta Dental Of New York
One Delta Drive

Mechanicsburg, PA 17055

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.

J. 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.

K. 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. Hygiene. Oral hygiene, plaque control programs or dietary instructions.

5. Implants. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

6. Medical services. Services that, to any extent, are payable under any medical expense benefits of the Plan.

7. No listing. Services which are not included in the list of covered dental services.

8. Orthodontia. Orthodontic treatment and orthognathic surgery.

9. Personalization. Personalization of dentures.

10. Replacement. Replacement of lost or stolen appliances.

11. 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.

PLAN EXCLUSIONS

Note: All exclusions related to Dental are shown in Paragraph K above

For all Medical/Prescription Benefits shown in the Schedules 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.** The applicable coordination of benefits provisions under the Humana Medicare Advantage Plan will apply for those who are covered by this Plan and another Plan. Please refer to those documents regarding the Medicare Advantage coordination of benefits provisions. If you find yourself covered by two or more dental plans/policies, the coordination of benefits rules in paragraphs 2-6 below will apply.

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.

OTHER BENEFITS

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.

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.

For purposes of this benefit the term "illness" means a bodily disorder, diseased, physical sickness, or mental disorder. Illnesses include, without limit, pregnancy, childbirth, miscarriage or complications of pregnancy.

Medicare Part B Premium Reimbursement

Covered Pensioners are eligible to be reimbursed for all or part of their Medicare Part B insurance premiums up to the standard Part B premium amount. 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 $1,735.20 in Part B insurance premiums on yourself for the year ending December 2020. Then in 2021 you may apply for reimbursement. In order to be reimbursed you must submit a copy of your 2020 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 as described in section 213(d) of the Internal Revenue Code and IRS Publication 502 while you are a Participant in the Plan, for yourself, your spouse or your dependent child, and these expenses are not otherwise covered by this Plan (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. costs of over-the-counter drugs and medicines and menstrual care items as permitted by the IRS (beginning January 1, 2020) with an itemized receipt;
f. Insurance Benefit deductibles, co-insurance and co-payments, and
g. 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.

Effective January 1, 2014, you may "opt out" of your Personal Account Plan benefits. If you opt out of your Personal Account Plan Benefits, you will forfeit any monies in your account as of the date you "opt out." You will be allowed to "opt out" of your Personal Account Plan Benefits in any month effective the first day of the following month. You are not required to waive or "opt out" of plan coverage for yourself or your dependents. It is your choice to decide on the medical coverage arrangements that are best for you and your family.

D. BENEFIT LIMITATIONS

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

Your total reimbursements for the Health Expense Benefit may not exceed $15,000 in any one Plan Year (July 1—June 30). **Effective January 1, 2022, the benefit plan year will be the calendar year (January 1 – December 31). There will be a short benefit plan year in 2021 (July 1 – December 31). Thereafter, the limits for this benefit will re-set each January 1st.**

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 (except as provided in Section II, Paragraph A for pensioners who return to covered employment).

F. EMPLOYEE ASSISTANCE PROGRAM

The Plan includes an Employee Assistance Program ("EAP") offered through Employee Assistance Group ("ESI"). This benefit provides you and your family with a confidential program offering resources and solutions relating to your financial, emotional, and mental well-being. You can learn more about the valuable benefits provided through the EAP program by calling (800) 252-4555 or (800) 222-2572 or by visiting www.theEAP.com.

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 – you may do this by electing pension deduction (recommended) or by self-paying directly to the Fund office.

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 AND SPECIAL ENROLLMENT RIGHTS

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 Human Medicare Advantage Plan. You may then enroll in the Humana Medicare Advantage Plan at such time as you lose coverage under your spouse's employer's health care plan, so long as you request enrollment within 2 months of your loss of such coverage.

Special Enrollment Rights for Dependents

There are several circumstances under which you may qualify for a special enrollment period to 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.

*****Special Temporary Plan Provision Relating to the COVID-19 Pandemic – Notwithstanding anything in this Paragraph B to the contrary, effective March 1, 2020, through 60 days following the announced end of the COVID-19 National Emergency (referred to as the "outbreak period"), any deadline for requesting special enrollment that falls within the "outbreak period" will be suspended until the earlier of: (a) one year following the applicable deadline; or (b) the end of the "outbreak period."***

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.

An Individual may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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 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. 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).

Other Coverage Options Besides COBRA Coverage

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

Interaction of COBRA and Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want

Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you. For more information on the Medicare initial enrollment period and 8-month special enrollment period, visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

***Special Temporary Plan Provision Relating to the COVID-19 Pandemic – Notwithstanding anything in this Paragraph E to the contrary, effective March 1, 2020 through 60 days following the announced end of the COVID-19 National Emergency (referred to as the "outbreak period"), any deadlines relating to the exercise of an individual's COBRA rights that fall during the "outbreak period" will be suspended until the earlier of: (a) one year from the applicable deadline; or (b) the end of the COVID-19 outbreak period**. *This means that every time an individual has a COBRA deadline that occurs on or after March 1, 2020, that deadline will be suspended for up to a year, as long as the COVID-19 outbreak period continues*.

Section V. Claim & Appeal Procedure

A. CLAIM PROCEDURE

Insured Medical Benefits: Claims for Medical Benefits Insured by Humana under the Medicare Advantage Plan (which includes medical and prescription benefits) are sent to:

Humana
P.O. Box 14601
Lexington, KY 40512

Dental Benefits: Claims for Dental Benefits administered by Delta Dental, the third-party administrator (TPA), are to be sent to:

Delta Dental Of New York
One Delta Drive
Mechanicsburg, PA 17055

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

Self-Funded, Self-Administered 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.

Self-Funded Vision Benefits Administered by NVA: Members that choose to use a non-participating provider may receive reimbursement based on their eligibility for benefits and the Plan maximums for the services received. Members simply submit a copy of the receipt along with a letter containing the member's full name, address, ID number, and group number to:

NVA
P.O. Box 2187
Clifton, NJ 07015

B. CLAIM DENIAL AND APPEAL

The terms of the Humana policy documents control your ability claims and appeals rights under the Medicare Advantage Plan. Please contact Humana for more information. You may also contact Labor First at (844) 818-1055 for more information about your medical and prescription drug benefits through the Humana Medicare Advantage Plan. You also have rights to appeal directly to Medicare if you disagree with a determination made by Humana. 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.

Appeals of NVA Vision Benefit Determinations

You, or your doctor (with your approval), have the right to ask NVA to review and change their decision when they have denied or reduced your benefits (referred to as an "adverse benefit determination"). Your appeal must be started not later than 180 days after the date of the denial letter sent to you by NVA. You may contact NVA or send a letter including your name and ID number, your doctor's name, that you wish to appeal NVA's decision and the reason you wish to appeal.

NVA will respond to your appeal within five business days (weekends and holidays do not count). If NVA does not approve the services you are asking for in your appeal, NVA will send you a letter explaining why.

Appeals of Fund Office and Delta Dental 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 Dental, or Post-Service Dental Claim, you must appeal to the TPA, Delta Dental of New York, within 180 days after you receive the initial adverse benefit determination. Vision benefit appeals must be sent to the TPA, NVA, within 180 days after you receive the initial adverse benefit determination (as described in the section above). To appeal an adverse determination of any other non-Humana Medicare Advantage Plan 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.

*****Special Temporary Plan Provision Relating to the COVID-19 Pandemic – Notwithstanding anything in this Paragraph B to the contrary, beginning March 1, 2020 through 60 days after the announced end of the COVID-19 National Emergency (referred to as the "outbreak period"), any participant deadlines relating to the exercise of your claims and appeals rights that fall during the "outbreak period" will be suspended until the earlier of: (a) one year from the applicable deadline; or (b) the end of the COVID-19 outbreak period****. This means that every time a participant a claim or appeal deadline occurs on or after March 1, 2020, that deadline will be suspended for up to a year, as long as the COVID-19 outbreak period continues.*

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 and Accidental Death and Dismemberment Claims: 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.

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.

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. All claims must be submitted to the Fund Office within 12 months of the date the expense was paid in order to be eligible for reimbursement.

D. INCOMPETENCE

In the event it is determined that a claimant is unable to care for their 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. If you are overpaid or otherwise paid in error, you are required to return any overpayment or erroneous payment.

G. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all covered Retirees and their covered spouses and dependents, with respect to the self-insured benefits provided under this Plan. You should review the Humana policy documents for any similar rules applicable under the Medicare Advantage 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 Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been “made whole”. The Plan’s rights to subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys’ fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees 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.

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.

- **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). *This provision applies to non-Medicare eligible dependent spouses covered under the terms of Plan A for active participants. You should review your Humana policy documents for any similar rights extended to Medicare eligible individuals under the Medicare Advantage Plan.*

- **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. *This provision applies to non-Medicare eligible dependent spouses covered under the terms of Plan A for active participants. You should review your Humana policy documents for any similar rights extended to Medicare eligible individuals under the Medicare Advantage Plan.*

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: *Ryan Heimroth, 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: *Ryan Heimroth, 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 *Ryan Heimroth, 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 *Ryan Heimroth, 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.

7. Right to Notification of a Breach

You have a right to receive notification in the event the Plan discovers unauthorized acquisition, access, use, or disclosure of your PHI which compromises the security or privacy of such information. Notification will be provided by mail to your last known address and will contain a brief description of the breach; a description of the types of unsecured PHI that were involved in the breach; the steps you should take to protect yourself from potential harm as a result of the breach; a brief description of what the Plan is doing to investigate the breach to mitigate harm to you, and to protect against further breaches; and the contact procedures to ask questions or learn additional information.

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 the Fund 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 filed in writing by mail, fax, email of via the OCR complaint portal at ocrportal.hhs.gov/ocr/smartscreen/main.jsf; (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 (HHS may extend the period if you can show "good cause").

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 July 1, 2021.

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: Ryan Heimroth, 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. Ryan Heimroth, 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.

Medical and prescription drug benefits are insured through a Humana Medicare Advantage Plan provided by Labor First.

PLAN BENEFITS PROVIDED BY: The United Association Local No. 7 Welfare Plan, Humana (Medicare Advantage Plan provided by Labor First), and self-insured dental benefits administered by Delta Dental of 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 July 1, 2021:

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

Daniel Keating
BPI Mechanical Services
PO Box 311
Waterford, NY 12188

Union

Timothy J. Carter
9 Carrolls Grove Road
Troy, NY 12180

Paul Fredericks
17 Barrows Street
Albany, NY 12209

Edward Nadeau, Business Manager
Plumbers & Steamfitters Local 7
18 Avis Drive
Latham, NY 12110

APPENDIX A

APPENDIX A

NVA SCHEDULE OF VISION BENEFITS

Examination Copay	$0
Lenses Only Copay	$0
Frames	$0
Contact Lenses	$0
Contact Lens Fit/Follow-Up Copay	$20 Standard Daily Wear/$30 Standard Extended Wear/$50 Specialty Wear

		Member Experience	
Benefits	**Frequency**	**In-Network**	**Out-of-Network**
Eye Examination			
Routine Examination	Once every 12 months	Covered 100%	$300 reimbursement maximum Total accumulated throughout the benefit period for: • Examination • Frames • Eyeglass lenses • Contact lenses • Lens options
Contact Lens Fit/Follow-Up[1]			
Standard Daily Wear	Once every 12 months	Covered 100%	
Standard Extended Wear	Once every 12 months	Covered 100%	
Specialty Wear	Once every 12 months	Covered 100%	
Lenses (Standard Glass or Plastic)			
Single Vision	Once every 12 months	$250 reimbursement maximum Total accumulated throughout the benefit period for: • Frames • Eyeglass lenses • Contact lenses • Lens options	
Bifocal	Once every 12 months		
Trifocal	Once every 12 months		
Lenticular	Once every 12 months		
Frames			
Retail Frame Allowance	Once every 12 months		
Contact Lenses (In addition to Eyeglasses)			
Elective	Once every 12 months		
Medically Necessary[2]	Once every 12 months		

To locate a participating provider, please visit:
www.e-nva.com

FIXED PRICING ON LENS OPTIONS			
Lens Option	**Fixed Fee**	**Lens Option**	**Fixed Fee**
Polycarbonate SV	$25	Progressives – Tier 1	$50
Polycarbonate BI	$30	Progressives – Tier 2	$80
Polycarbonate TRI	$30	Progressives – Tier 3	$100
Transitions SV (Standard)	$65	Progressives – Tier 4	$120
Transitions BI (Standard)	$70	Progressives – Tier 5	$140
Transitions TRI (Standard)	$70	Progressives – Tier 6	$165
Glass Photogrey SV	$20	Progressives – Tier 7	$190
Glass Photogrey BI	$30	Progressives – Tier 8	20% discount
Glass Photogrey TRI	$30	Polarized	$75
Anti-Reflective Coatings – Tier 1	$40	High Index	$55
Anti-Reflective Coatings – Tier 2	$50	Blended Bifocals (Segment)	$30
Anti-Reflective Coatings – Tier 3	$65	Solid Tints	$10
Anti-Reflective Coatings – Tier 4	$80	Fashion Gradient Tints	$12
Anti-Reflective Coatings – Tier 5	20% discount	Blue Light Blocker (Standard)	$40
Scratch-Resistant Coating (Standard)	$10	Blue Light Blocker (Premium)	$60
UV Coating	$12	Blue Light Blocker (Ultra)	$150
Note: Members pay the lower of the fixed price or 20% off the provider's usual and customary price. Fixed prices are available in-network only. Members receive a 20% courtesy discount on lens options not listed above. Fixed prices/courtesy discount do not apply at Walmart/Sam's Club locations. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.			

Added-Value Services Included	
Mail Order Contact Lens Replacement Program	See **Appendix** section for more details about the NVA Mail Order Contact Lens Replacement Program
Lasik Discount	Extensive discounts at participating LASIK Providers. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

After the enrolled member has exhausted their funded benefit, they are eligible to access the EYEESSENTIAL® Plan discount on additional purchases during the plan period.

NVA introduces the EYEESSENTIAL® Discount Plan – a low cost, member-friendly vision discount plan which includes significant discounts on materials through participating NVA network providers. Below is the plan design.

Service or Material	**Member Cost**
Comprehensive Vision Examination (Including dilation as professionally indicated)	Balance after $10 Discount
Lenses	**Standard Glass or Plastic**
Single Vision	$35.00
Bifocal	$55.00
Trifocal	$70.00
Lenticular	$70.00
Lens Options	
UV Coating	$12.00

Tint (Solid & Gradient)	$12.00
Scratch-Resistant Coating (Standard)	$15.00
Polycarbonate (Standard)	$35.00
Anti-Reflective Coating – Tier 1	$45.00
Polarized	$75.00
Transitions (Standard)	Single Vision - $65.00 / Bifocal & Trifocal - $70.00
Progressive – Tier 1 & Tier 2	$50.00 + Bifocal/Trifocal Charge
Other Add-On Services	20% off retail
Frames (Any eligible frame at provider's location)	35% off retail
Contact Lenses (Discount does not apply at Contact Fill)	
Conventional	15% off retail price
Disposable	10% off retail price
Fitting and Follow Up	10% off retail price

Please Note: The NVA EYEESSENTIAL® Plan is available at an in-network provider only. Frequency of use is unlimited. EYEESSENTIAL® Discount Program prices do not apply at select retail locations including Walmart/Sam's Club locations. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Exclusions (Standard Exclusions unless otherwise identified in the Schedule of Benefits)

The following are not payable under this Policy unless otherwise indicated in the Schedule of Benefits:

1. Professional services and/or materials in connection with: Plano (non-prescription) lenses; Aniseikonic Lenses; Subnormal visual aids; Orthoptics, vision training, developmental vision procedures, and any associated supplemental testing.
2. Broken, lost or stolen lenses, contact lenses, or frames. NVA network providers may offer additional warranties to cover materials.
3. Services or materials, which are payable under any workers' compensation act, similar law or any public program, other than Medicaid.
4. Services or materials rendered by a provider other than ophthalmologists, optometrists, or opticians acting within the scope of their licensure.
5. Any additional service required outside basic vision analysis for contact lenses, including but not limited to fitting fees, unless otherwise specified in the Proposed Schedule of Benefits.
6. Services rendered after the date a person ceases to be covered under this policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the person within 31 days from the date of such order.
7. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan.
8. Medical and/or surgical treatment of the eye, eyes or supporting structures.
9. Two pairs of glasses in lieu of bifocals.