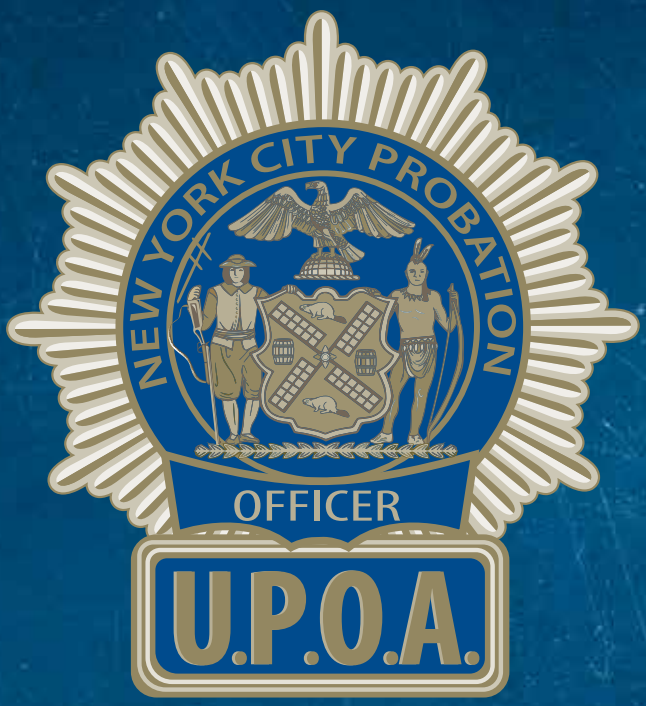

United Probation Officers Association

ACTIVE WELFARE FUND
SUMMARY PLAN DESCRIPTION

UNITED PROBATION OFFICERS ASSOCIATION

WELFARE FUND

2510 Westchester Ave., Suite 207 • Bronx, NY 10461 • P: 212.226.1069 • F: 917.398.1640 • www.upoa.com

Dear Welfare Fund Participant,

The Trustees are pleased to issue this Welfare Fund Benefits Booklet that provides a description of your current benefits and information on filing claims. The benefits detailed in this booklet are furnished by the United Probation Officers Association Welfare Fund ("Fund") and are supplemental to your elective New York City health plan. Your rights and responsibilities under the Fund also are outlined in this booklet.

We urge you to read this booklet carefully and keep it available for future reference. While all information printed within is accurate as of the date this booklet was produced, you will always find the most updated and accurate information on our website at **www.upoa.com**. Members are responsible for adhering to the information outlined in this booklet.

If you have any questions, feel free to contact the Welfare Fund at 212.226.1069.

Sincerely,

Board of Trustees
United Probation Officers Association Welfare Fund

Table of Contents

INTRODUCTION

The Board of Trustees of the Fund is pleased to provide you with this Welfare Fund Benefits Booklet, formally known as a Summary Plan Description (SPD). An SPD describes the benefits available to you and your covered dependents under the Fund's Plan. It includes summaries of:

- Who is eligible;
- Services that are covered;
- Services that are not covered;
- How benefits are paid; and
- Your rights and responsibilities under the Plan.

By its nature, the SPD is a condensation of many pages of contracts that the Fund holds with a number of insurance carriers and vendors. The Trustees have used best efforts to assure that these terms are conveyed completely, accurately, and in useable form. To the extent that ambiguities are perceived, or interpretation differs, the contracts govern and supersede language employed herein.

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. Although the Trustees intend to continue the programs and benefits described in this Plan, the Trustees continue to reserve the right, subject to the applicable provisions of the Plan documents and any applicable collective bargaining agreement, to modify, change, revise, amend, or terminate any of the plans or programs of benefits.

ELIGIBILITY RULES

Who Is Eligible

You are eligible for these benefits if:

a. You are a full-time employee of the City of New York, Department of Probation; and
b. Your employment is the subject of a Collective Bargaining Agreement by and between the United Probation Officers Association and the City of New York; and
c. You are enrolled in the Plan; and
d. The Fund receives a contribution from the City on your behalf.

No benefits are available until enrollment is completed and processed.

When You Become Eligible

Eligibility commences as soon as the above requirements are met.

Eligible Dependents

Your eligible dependents under this Plan are:

1. Your lawful spouse OR your qualified domestic partner;

   In order to register for coverage as a qualified domestic partner in the Plan, you must be an unmarried individual who:

   - Is at least 18 years of age; and
   - Is unrelated by blood to the unmarried member; and
   - Has a close committed personal relationship with the unmarried member; and
   - Has a shared household with an unmarried member on a continuous basis for at least 12 months prior to the request for coverage; and
   - Is not a member of another domestic partnership.

The member electing domestic partner coverage, and his/her/their domestic partner, must have jointly executed a Affidavit of Domestic Partnership and submit such documentation and other proof that may be required by the Fund's Trustees to the Fund Office. An original Certificate of Domestic Partnership, issued by the City of New York or any other municipal agency, certifying that the domestic partnership is a legal relationship permitted under the laws of the State of New York is presumptively acceptable proof of domestic partnership and may be submitted in lieu of the Fund's Affidavit of Domestic Partnership.

2. Your **unmarried children** from birth to their 26th birthday provided they depend upon you for support and maintenance and are not employed on a full-time basis. However, a child who is physically or mentally incapable of self-support upon attaining age 26 and is an eligible dependent may be continued as a dependent under the Plan while remaining incapacitated and unmarried, subject to your own coverage continuing in effect.

   Stepchildren, foster children, legally adopted children (including a "proposed adopted child" during any waiting period prior to the finalization of the child's adoption), and children for whom you act as a legal guardian may be considered eligible dependents the same as your own children only if they depend on you for support and maintenance, and you provide the Fund Office with documentary proof of your relationship. No child other than the one with whom you have one of the specified relationships designated above may be considered an eligible dependent, regardless of whether the child lives with you or depends on you for support and maintenance.

The Plan may also provide coverage pursuant to a qualified medical child support order issued by a court or administrative agency of competent jurisdiction, provided it clearly specifies the alternate recipient, reasonably describes the benefits to be provided to such alternate recipient, and clearly states the period to which the order applies.

No new dependent will be recognized for coverage under the Plan until they have been reported to the Fund Office by the member. Appropriate documentation of eligibility as a covered dependent (e.g. birth certificate, marriage certificate, etc.) must be submitted to the Fund Office along with notification of newly acquired dependent. Coverage for such dependent will begin on the first day of the month following proper notification. Newly reported dependents are subject to all Plan rules and guidelines. A new dependent is defined as an individual who becomes a dependent of a member after the member is eligible to receive benefits.

No one will be eligible to be covered as a dependent while covered as a member of the Plan or while in military service, except as provided under USERRA or other applicable federal or state law.

Termination of Coverage and Insurance

The benefits for you and your eligible dependents will terminate on the day when any of the following occurs, unless otherwise noted:

1. If you cease to be an eligible member for any reason other than death, your eligibility ends on the last day you worked;
2. If the Plan is discontinued or a specific benefit is terminated;
3. A dependent's coverage will terminate when he/she is no longer an eligible dependent, as defined by the Plan and/or when your coverage terminates;
4. If you take a leave from covered employment for service in the Uniformed Services of the United States, contact the Fund Office for information; or
5. In the case of death, eligibility for dependents will end 45 days after member dies.

QUESTIONS CONCERNING THE PLAN

Contact the Fund Office at 212.226.1069 should you have any questions concerning the Plan.

SCHEDULE OF BENEFITS

Unless otherwise noted, the following benefits apply to UPOA active members in good standing, their spouses, and their eligible dependents.

Anesthesia
Annual max/family up to $500

Childbirth (Member Only)
Once/delivery (natural birth) $1,800
Once/delivery (Cesarean section). $2,400

Death (Member Only). $10,000

Dental
Annual max/person up to. $4,000

Disability (Member Only)
Max/week up to 26 weeks. $300
Lifetime max $10,000

Education (Member Only)
Annual maximum. $250

Emergency Room
Annual max/person up to. $150

Hearing Aid
Once every two years/family member up to. $1,000

Legal Services (Member Only)

Medical Co-Pay
Annual max/family up to. $700

Non-Drug Health & Fitness Reimbursement
Annual max/family up to. $300

NOTE: Please see full description of this benefit on page 24 for breakdown of what is included and specifically excluded, as well as what is for Member Only and what is for Spouse and Eligible Dependents.

Optical
Member: max/two-year period up to $600
Eligible Family Member: max/two-year period up to $400

Laser Eye Surgery (Member Only)
One-time benefit, max of $1,500
Disqualifies you from future corrective lenses/contacts under the Optical Benefit

Podiatry
Annual max/family member up to. $200

Prescription Drug
Annual max/family up to. $2,500

Prosthetic
Lifetime max/family $2,500

Rehabilitation
Annual max/family up to. $300

HOW TO APPLY FOR BENEFITS

The process to apply for any of the benefits listed in the Schedule of Benefits begins by going to the UPOA website at **www.upoa.com** and downloading the appropriate Benefit Claim Form. Submit the completed form along with the required paperwork as described on the following pages under each benefit to the UPOA Welfare Fund.

Completed forms and documents can be uploaded to **www.asonet.com** or mailed to the UPOA Welfare Fund, 2510 Westchester Avenue, Suite 207, Bronx, NY 10461. Once claims have been uploaded to the ASO website, all questions should then be referred to the UPOA Welfare Fund at 212.226.1069.

Dental claim forms **ONLY** should be mailed to UPOA Welfare Fund, PO Box 9005, Dept. 20, Lynbrook, NY 11563.

Incomplete paperwork, itemized receipts that do not contain all of the required information, claim forms that are not signed, or claims submitted after the deadline, will **not** be considered for reimbursement. Please double check everything before submitting to the Fund Office.

If it is necessary for you to retain any original paperwork, be sure to request a duplicate copy from the pharmacy as the Fund will not return any receipts.

ANESTHESIA BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse up to a maximum of $500 per family per year toward the cost of out-of-pocket anesthesia expenses related to surgery performed either in a hospital or an out-patient facility.

How to Apply for the Anesthesia Benefit

1. Submit the Anesthesia Benefit Claim Form along with the anesthesiologist's bill and proof of payment and/or Explanation of Benefits from your health insurance carrier.
2. Any claim for reimbursement must be submitted to the Fund Office **no later than one year from date service is rendered.**

CHILD BIRTH BENEFIT

MEMBER

Active members can file for the Childbirth Benefit once per delivery and be reimbursed $1,800 for a natural delivery or $2,400 for a Cesarean section (C-section).

How to Apply for the Childbirth Benefit

1. Submit the Childbirth Claim Form along with proof from your medical practitioner (OB/GYN, Nurse Practitioner, Midwife, etc) stating **date of birth and type of birth** (natural or Cesarean section (C-section)) as reimbursement rates are different.
2. Forms and accompanying documentation must be submitted within 90 days of delivery.

DEATH BENEFIT

MEMBER

Upon the death of an active member, his/her named beneficiary shall receive a one-time $10,000 death benefit. If no beneficiary is identified, the death benefit will be paid to the estate of the deceased member.

How to Apply for the Death Benefit

1. Submit the Death Benefit Claim Form and an original death certificate.
2. Forms and accompanying documentation must be submitted within one year of member's death.

DENTAL BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The list of dental benefits described in this section includes all the recent changes and improvements. The Plan has been designed to help defray the cost of dental care and the level of these benefits is dependent on the prudent and judicious use of the contributions received. The Trustees continuously review the level of benefits and services being covered to provide the most comprehensive coverage possible within the framework of the Plan.

Benefits Payable

When dental services, as listed in the Dental Schedule, are performed after the effective date of your dental insurance, payment will be made for the dentist's charges up to the amounts shown in the Dental Schedule of Plan Allowances starting on page 13.

Deductible

There is no deductible for dental benefits.

Maximum Amount Payable

The maximum amount payable for each covered individual will be $4,000 in any calendar year.

Panel of Participating Dentists

When you use an ASO Fund Participating Dentist, you will be provided with the services listed in the Schedule of Covered Dental Expenses without any out-of-pocket expenses for most covered and reimbursable services. Since usual and customary dental charges generally exceed the dental plan allowances, this represents an overall savings to you in the cost of your dental services.

It is important to understand that when you obtain your dental services from a Participating Dentist, it does not in any way change the nature of the dental program. Your eligibility is determined in the same way. You are free to select the dentist of your choice and claims procedures will remain the same insofar as you are concerned.

However, if you use a Participating Dentist, you will be expected to execute an Assignment of Benefits on the claim form so the Participating Dentist can be paid directly by the Fund. If you use a non-participating dentist, the Fund will pay up to the maximum allowance set forth in the dental schedule, and you will be responsible for the difference between that allowance and your dentist's charges.

To use a Participating Dentist, select one from the List of Participating Dentists located on ASO's website at **www.asonet.com** and call for an appointment. Should you want any assistance with the program, have any specific complaints or suggestions, or require a List of Participating Dentists (there are occasional additions and deletions), please contact the Fund's dental plan administrator, ASO, at 516.396.5500.

While the Fund makes every reasonable effort to ensure the accuracy of the information provided in this booklet, the Fund reserves the right to correct any errors. Neither the Fund nor its affiliated entities make any representations or warranties of any kind or any nature, whether express or implied, created by law, contract, or otherwise, including, without limitation, any representations regarding listed dentists. Please verify with dentist when calling to schedule an appointment if that dentist is currently on the List of Participating Dentists with the Plan.

The Fund's Dental Plan Administrator will monitor costs submitted by participating dentists to ensure charges for services do not exceed those listed in the Fund's Dental Schedule. Accordingly, be aware that you should not be billed except in the following few situations:

- For those services where a copayment is indicated;
- For those services listed in the covered Dental Schedule, but which the Plan excludes from coverage (e.g. cosmetic restorations, payments in excess of plan maximums or frequency limitations). Your dentist's charges may not exceed Plan allowances for those services;
- For an unlisted, non-covered service (there are a few procedures not included in the Fund Dental Schedule). You are not to pay more than the dentist's usual and customary charge for that service; and
- If you or your family members are beneficiaries under more than one dental plan, the dentist is entitled to the benefits available from both plans. The combined payment for any procedure, however, may not exceed 100% of the usual and customary fee for that procedure.

Covered Expenses

Covered dental expenses include charges for dental services provided for in the Schedule of Dental Services when performed by or under the direction of a licensed dentist and which begin and are completed while the individual is covered for benefits.

A dental service is deemed to start when crowns, inlays, fixed bridgework, and full or partial dentures or teeth were prepared, and/or impressions were taken; or for root canal therapy, when the pulp chamber of the tooth is opened.

Alternate Benefits Provision

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could provide a suitable result based on common dental standards. In these instances, the Fund will determine the Alternate Course of Treatment on which payment will be based and the expenses that will be included as Covered Expenses. You may, however, elect to follow your dentist's initial Course of Treatment and be responsible for charges that exceed Plan allowances for the Alternate Course of Treatment. Before deciding upon an alternate course of treatment, you may obtain an opinion from the Fund regarding the appropriateness of the recommended treatment.

Extension of Benefits

A dental service completed after a person's eligibility for benefits ceases will be deemed a covered expense if:

- For inlays, crowns, fixed bridgework, and full or partial dentures, a pre-treatment authorization was issued, teeth were prepared, and impressions were taken while that person was eligible and the appliance was inserted within one month after that person's eligibility terminated.

- For root canal therapy, treatment was begun while that person was eligible for benefits and completed within one month after that person's eligibility terminated.

Pre-Determination of Benefits

Pre-treatment Review is not mandatory, but highly recommended. You may take advantage of this process so you and your dentist can be informed, in advance of treatment and before any expenses are incurred, what benefits are provided by the Dental Program.

This process is designed to inform the patient and dentist, in advance of treatment, which benefits are provided by the dental plan. It enables you to obtain full knowledge of your dental plan prior to undertaking treatment and incurring expenses. The process identifies coverage and limitations, and specifies scheduled allowances.

You are expected to maintain your own records regarding the allowable annual maximum of $4,000, thereby making you aware that even when a proposed dental procedure is approved for reimbursement, you will not be paid for any charges in excess of the annual maximum.

A claim form for Pre-Treatment Review should be filed by your dentist if the course of treatment prescribed for you is expected to cost more than $300 in a 90-day period and/or includes any of the following services: inlays, crowns, bridges, dentures, laminate veneers, and/or periodontal surgery.

The dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary x-rays and other supporting documentation to the Fund Office.

The Fund will review the proposed treatment and apply the appropriate plan provisions. You and your dentist will receive a report showing plan allowances for each procedure. If there are disallowances, these will also be indicated, along with an explanation for the disallowances.

Discuss the treatment plan and the benefits payable with your dentist. If you receive a Pre-Treatment Authorization for a proposed course of treatment that was submitted by one dentist, that pre-authorization will remain valid if you elect to have some or all of the work done by another dentist. The pre-authorization will be honored for one year after issuance.

A Pre-Treatment Authorization is not a promise of payment. Such authorization requires that work must be done while you are still covered by the Fund for benefits (except where there is an extension of benefits as previously described) and that no significant change occurred in the condition of your mouth after pre-authorization was issued. Payment will be made in accordance with Plan allowances and limitations in effect at the time services are provided.

NOTE: You should maintain your own records regarding the allowable annual maximum of $4,000 because this Plan will not pay dental benefits in excess of that amount for an individual in one calendar year.

Expenses Not Covered

No payment will be made for the following **explicitly excluded services:**

1. Cosmetic restoration;
2. Replacement of a lost or stolen appliance;
3. Replacement of a bridge, crown, or denture that is or can be made usable according to common dental standards;
4. Replacement of bridges, crowns, or dentures within five years after the date of original installation;

5. Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
   a. Change vertical dimension;
   b. Diagnose or treat conditions or dysfunctions of the temporomandibular joint;
   c. Stabilize periodontally involved teeth; or
   d. Provide multiple bridge abutments
6. Dental services that do not meet common dental standards; or
7. Services for which benefits are not payable according to the "General Limitations" section below.

General Limitations

No payment will be made for expenses incurred for you or any of your eligible dependents:

1. For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit that is covered under Workers' Compensation or similar law;
2. For, or in connection with, a sickness that is covered under any disability insurance or similar law;
3. To the extent that they are more than Reasonable and Customary Charges;
4. For charges for unnecessary treatment;
5. To the extent that you or any of your eligible dependents are in any way paid or entitled to payment for those expenses by or through a public program; or
6. For procedures and materials not approved by the American Dental Association or the appropriate dental specialty society

How Benefits are Paid

1. After dental work is performed, have your dentist complete all items in the Dentist Information portion of the claim form and list the procedures, dates of services, and charges, and sign in the space provided for dentist signature.
2. Complete all items in the Member Information portion. Be sure to include spouse and eligible dependent information where applicable.
3. Completed claim forms with x-rays and other attachments should be sent to the Fund's dental plan administrator. Claim forms are available from the UPOA website at **www.upoa.com** or the dental plan administrator's website at **www.asonet.com**
4. Dental claims must be filed within 12 months of the date of service completion. Claims filed later than 12 months from the date of service will not be reimbursed. If you would like the payment made directly to your dentist, sign the "Authorization to Assign Benefits" box on the claim form. Reimbursement will be in accordance with the fees listed in the Schedule of Allowances, not to exceed actual dentist charges.

Second Dental Opinion

The Fund may also require you to get a second dental opinion based on the Fund's concerns of the current treatment plan.

Orthodontics

MEMBER ■ Active members will be covered for orthodontic treatment up to 30 months for traditional braces **OR** up to $2,700 for Invisalign.

ELIGIBLE DEPENDENTS ■ Dependents up to age 26 will be covered only for traditional braces up to 30 months.

DENTAL SCHEDULE OF PLAN ALLOWANCES

UNITED PROBATION OFFICERS RETIREE WELFARE FUND
UPOA WF AND METRODENT PREMIER PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	• Eligibility is determined according to the definition and requirements outlined in the United Probation Officers Association Welfare Fund Summary Plan Description. Eligible dependents include the lawful spouse, domestic partners and unmarried children until the end of the month in which the child attains age 26.
PLAN YEAR	• January 1 - December 31
PLAN MAXIMUM	• $4,000 annual maximum per covered family member
DEDUCTIBLE	• There is no deductible
ORTHODONTIC MAXIMUM	• Member, and eligible dependents up to age 26, are covered • Subject to Annual Maximum
PLAN LIMITATIONS	• Examination: 1 every 6 months • Prophylaxis: 1 every 6 months • Replacement of prosthetics: Not more than once in five years • Palliative treatment: No other treatment rendered that same visit • Fluoride treatment: To age 19, 1 every 6 months • Sealants: To age 16, permanent posterior teeth only, maximum 2 per lifetime • Root Scaling, curettage, bite correction; any combination, including prophylaxis: Maximum 1 per 6 months • Periodontal surgery: Charting and x-rays required; once in 36 months • Rebasing or relining denture: Once in 36 months • Implants: 1 implant per family per calendar year. Participating providers are not required to accept plan allowance as payment in full.
PRE-TREATMENT REVIEW	• This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. Please note- a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible. • Pre-op periapical x-rays required for crowns, veneers, inlays and extractions • Periodontal charting and x-rays are required for surgical periodontal procedures • Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework
COORDINATION OF BENEFITS	• If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate co-payments, deductibles, or charges levied due to maximums.
HOW TO FILE A CLAIM	• As a participating provider, you must complete all necessary paper work and accept assignment of benefits. • Claims must be filed no later than 12 months from date of service. • Complete a Claim Form (computer generated, ADA, and universal claim forms are accepted) and provide an itemized bill of services rendered. • Enclose, when appropriate, x-rays, tooth charting, periodontal charting • Mail claims to: Administrative Services Only, Inc. P.O. Box 9005 Dept 20 Lynbrook, NY 11563 • File claims electronically: PAYOR ID: CX076

For up to date detailed information, including member eligibility, please access our website at: **www.asonet.com**
If you have any questions regarding the operation of this program please contact ASO at 516.396-5500

Eff. 01/22

DENTAL SCHEDULE OF PLAN ALLOWANCES

DIAGNOSTIC AND PREVENTIVE		
CODE	**DESCRIPTION**	**ALLOWANCE**
D0120	Periodic Oral Examination	$30
D0140	Limited Oral Evaluation	$50
D0150	Compehensive Oral Examination	$30
D0180	Compehensive Periodontal Evaluation	$45
D0210	X-Rays — Full Mouth	$50
D0220	Periapical X-Ray First Film	$7
D0230	X-Ray Periapical — Additional	$7
D0240	Occlusal Film	$14
D0270	X-Ray 1 Bitewing	$7
D0272	X-Ray 2 Bitewings	$13
D0273	X-Ray 3 Bitewings	$18.15
D0274	X-Ray 4 Bitewings	$25
D0277	Vertical Bitewings 7-8 Films	$42.35
D0330	Panoramic Film	$45
D1110	Prophylaxis	$40
D1120	Prophylaxis — Child	$35
D1206	Topical Fluoride Varnish	$18
D1208	Topical Application Fluoride	$18
D1351	Sealant	$15
D1352	Preventive Resin Restoration	$30.25
D1510	Space Maintainer — Fixed	$150
D1520	Space Maintainer — Removable	$150
D1526	Space Maintainer — Removable — Bilateral, Maxillar	$151.25
D1527	Space Maintainer — Removable — Bilateral, Mandibul	$151.25

DENTAL SCHEDULE OF PLAN ALLOWANCES

RESTORATIVE		
CODE	**DESCRIPTION**	**ALLOWANCE**
D2140	Amalgam One Surface — Permanent or Primary	$45
D2150	Amalgam Two Surfaces — Permanent or Primary	$55
D2160	Amalgam Three Surfaces — Permanent or Primary	$60
D2161	Amalgam Four Surfaces — Permanent or Primary	$80
D2330	Resin — One Surface	$52
D2331	Resin — Two Surfaces	$60
D2332	Resin — Three or More Surfaces	$70
D2335	Resin — 4+ Surfaces or Incisal Edge	$80
D2391	Resin — One Surface Posterior	$50
D2392	Resin — Two Surfaces Posterior	$60
D2510	Inlay — Metallic — One Surface	$200
D2520	Inlay — Metallic — Two Surfaces	$230
D2651	Inlay — Composite — Two Surfaces	$42.35
D2652	Inlay — Composite — Three Surfaces	$42.35
D2710	Crown — Resin — Laboratory	$275
D2721	Crown — Resin with Base Metal	$485
D2750	Crown — Porcelain Fused to Metal	$485
D2751	Crown — Porcelain Fused to Base Metal	$425
D2752	Crown — Porcelain Fused to Noble Metal	$485
D2790	Crown — Full Cast Metal	$485
D2910	Recement Inlay	$30
D2920	Recement Crown	$30.25
D2931	Stainless Steel Crown — Permanent	$200
D2951	Pin Support Per Tooth	$25
D2952	Cast Post & Core	$133.10

DENTAL SCHEDULE OF PLAN ALLOWANCES

RESTORATIVE		
CODE	DESCRIPTION	ALLOWANCE
D2954	Prefab Post & Core	$110
D2961	Resin Laminate — Laboratory	$467.50
D2962	Porcelain Laminate	$302.50
D2980	Repair Broken Crown Facing	$66.55

ENDODONTICS		
CODE	DESCRIPTION	ALLOWANCE
D2310	Pulp Cap — Direct	$18.15
D3220	Vital Pulpotomy	$75
D3310	Root Canal Therapy — Anterior Tooth	$360
D3320	Root Canal Therapy — Bicuspid Tooth	$410
D3330	Root Canal Therapy — Molar Tooth	$475
D3410	Apicoectomy — First Root	$181.50
D3421	Apicoectomy — Premolar — First Root	$181.50
D3425	Apicoectomy — Molar — First Root	$181.50
D3426	Apicoectomy — Each Additional Root	$121
D3430	Retrograde Filling	$85
D3920	Hemisection	$150

DENTAL SCHEDULE OF PLAN ALLOWANCES

PERIODONTICS		
CODE	DESCRIPTION	ALLOWANCE
D4210	Gingivectomy or Gingivoplasty	$363
D4260	Osseous Surgery — Per Quadrant	$375
D4270	Pedicle Soft Tissue Grafts	$250
D4277	Free Soft Tissue Graft	$148.50
D4320	Splinting — Intracoronal	$108.90
D4341	Perio Treatment Per Quad	$50
D4342	Scaling — Root Planing 1-3 Teeth	$38
D4355	Full Mouth Debridement	$75
D4910	Periodontal Maintenance	$50

PROSTHODONTICS **Please Note: Participating providers are NOT required to accept the plan allowances for implant-related services as payment in full.**		
CODE	DESCRIPTION	ALLOWANCE
D5110	Complete Upper Denture	$600
D5129	Complete Lower Denture	$600
D5130	Immediate Full Upper Denture	$600
D5140	Immediate Full Lower Denture	$600
D5211	Upper Partial — Acrylic Base W/C	$425
D5212	Lower Partial — Acrylic With Clasps	$425
D5213	Upper Partial — Cast Metal	$600
D5214	Lower Partial — Cast Meal	$600
D5282	Removable Unilateral Partial Denture Maxillary	$375
D5283	Removable Unilateral Partial Denture Mandibular	$375

DENTAL SCHEDULE OF PLAN ALLOWANCES

PROSTHODONTICS **Please Note: Participating providers are NOT required to accept the plan allowances for implant-related services as payment in full.**		
CODE	**DESCRIPTION**	**ALLOWANCE**
D5110	Complete Upper Denture	$600
D5129	Complete Lower Denture	$600
D5130	Immediate Full Upper Denture	$600
D5140	Immediate Full Lower Denture	$600
D5211	Upper Partial — Acrylic Base W/C	$425
D5212	Lower Partial — Acrylic With Clasps	$425
D5213	Upper Partial — Cast Metal	$600
D5214	Lower Partial — Cast Meal	$600
D5282	Removable Unilateral Partial Denture — Maxillary	$375
D5283	Removable Unilateral Partial Denture — Mandibular	$375
D5410	Adjust Complete Denture — Upper	$35
D5511	Repair Broken Complete Denture Base — Mandibular	$55
D5512	Repair Broken Complete Denture Base — Maxillary	$55
D5611	Repair Resin Partial Denture Base — Mandibular	$90
D5612	Repair Resin Partial Denture Base — Maxillary	$90
D5621	Repair Cast Partial Framework — Mandibular	$100
D5622	Repair Cast Partial Framework — Maxillary	$100
D5640	Replace Broken Tooth	$85
D5650	Add Tooth to Denture	$85
D5660	Add Clasp to Existing Partial Denture	$85
D5730	Reline Complete Maxillary Denture (Chairside)	$80
D5731	Reline Complete Mandibular Denture (Chairside)	$80
D5740	Reline Maxillary Partial Denture (Chairside)	$80

DENTAL SCHEDULE OF PLAN ALLOWANCES

PROSTHODONTICS **Please Note: Participating providers are NOT required to accept the plan allowances for implant-related services as payment in full.**		
CODE	**DESCRIPTION**	**ALLOWANCE**
D5741	Reline Mandibular Partial Denture (Chairside)	$80
D5750	Reline Upper Denture — Lab	$125
D5751	Reline Comp Lower Denture — Lab	$125
D5760	Reline Partial Upper — Lab	$100
D5761	Reline Partial Lower — Lab	$100
D5850	Tissue Conditioning — Maxillary	$40
D5851	Tissue Conditioning — Lower	$40
D6010	Endosteal Implant	$1,000
D6057	Custom Abutment	$467.50
D6058	Abutment Supported Porcelain Ceramic Crown	$467.50
D6059	Abutment Supported Porcelain Metal Crown	$467.50
D6060	Abutment Supported Crown Base Metal	$467.50
D6061	Abutment Supported Crown	$467.50
D6062	Abutment Supported Cast High Noble	$467.50
D6063	Abutment Supported Base Metal	$467.50
D6064	Abutment Supported Cast Noble Crown	$467.50
D6065	Implant Supported Porcelain Ceramic Crown	$467.50
D6066	Implant Supported Porcelain high Noble	$467.50
D6067	Implant Supported High Noble Metal	$467.50
D6240	Pontic — Porcelain Fused to Metal	$425
D6241	Pontic — Porcelain Fused to Base Metal	$330
D6242	Pontic — Porcelain Fused to Noble Metal	$467.50
D6252	Pontic — Resin With Noble Metal	$412.50

DENTAL SCHEDULE OF PLAN ALLOWANCES

PROSTHODONTICS **Please Note: Participating providers are NOT required to accept the plan allowances for implant-related services as payment in full.**		
CODE	**DESCRIPTION**	**ALLOWANCE**
D6545	Maryland Bridge Retainer	$302.50
D6750	Abutment — Porcelain Fused to Metal	$425
D6751	Abutment — Porcelain Fused to Base Meal	$425
D6752	Abutment — Porcelain Fused to Noble Metal	$425
D6930	Recement Bridge	$40

ORAL SURGERY		
CODE	**DESCRIPTION**	**ALLOWANCE**
D7140	Extraction Erupted Tooth or Exposed Root	$60
D7210	Surgical Extraction	$90
D7230	Removal — Partial Bony Impacted	$185
D7240	Removal — Complete Bony Impacted	$225
D7250	Removal of Residual Roots	$90
D7251	Coronectomy	$120
D7280	Surgical Exp-Imp/Erup (for Ortho)	$155
D7285	Biopsy — Hard Tissue	$100
D7286	Biopsy — Soft Tissue	$100
D7320	Alveolectomy — Per Quadrant — No Ext	$133.10
D7413	Excision of Tumor < 1.25	$84.70
D7414	Excision of Benign Tumor > 1.25	$121
D7510	Incision and Drainage	$165
D7960	Frenulectomy	$95

DENTAL SCHEDULE OF PLAN ALLOWANCES

ORTHODONTICS		
CODE	**DESCRIPTION**	**ALLOWANCE**
D8080	Initial Orthodontic Appointment — Adolescent	$700
D8670	Active Orthodontic Treatment Per Month	$65

ADJUNCTIVE		
CODE	**DESCRIPTION**	**ALLOWANCE**
D9110	Palliative Treatment	$60
D9222	Deep Sedation/General Anesthesia — First 15 Minutes	$75
D9223	Deep Sedation/General Anesthesia — Each 15 Minutes	$75
D9230	Analgesia	$18.15
D9239	Intravenous Moderate (Conscioius) Sedation/Analgesia	$25
D9243	Intravenous Moderate (Conscious) — 15 Minutes	$25
D9310	Specialist Consultation	$50
D9944	Occlusal Guard — Hard Appliance, Full Arch	$110
D9945	Occlusal Guard — Soft Appliance, Full Arch	$110
D9952	Occlusal Adjustment — Complete	$90.75

DISABILITY BENEFIT

MEMBER ■

In order to receive the Disability Benefit, Active Members **must be off payroll** for seven days. The Disability Benefit will be paid beginning on the eighth day payroll is terminated. The maximum benefit per week for up to 26 weeks is $300 and the lifetime maximum is $10,000. It is not necessary to be confined in a hospital to receive these payments, but you must be under a doctor's care during your disability, and your doctor must provide written medical verification of your disability.

Successive Disabilities

Successive disabilities due to injuries received in the same accident, or due to the same or a related sickness, will be considered as one disability unless the disabilities are separated by your return to work for six months.

How to Apply for the Disability Benefit

1. Submit the Childbirth Claim Form and a physician's diagnosis, prognosis, and expected date of return to work.
2. For continuing benefit payments beyond your original expected return-to-work date, you must submit updated medical verification from your treating physician at least five (5) days prior to the requested return-to-work date. Non-compliance will automatically cancel your Disability Benefit.

NOTE: It is in a member's best interest to keep in constant communication (e.g. a short email) with the UPOA/WF during your leave on Disability by providing regular updates in order not to jeopardize your Disability Benefit in any way.

EDUCATION BENEFIT

MEMBER ■

The Fund will reimburse tuition and registration fees up to a maximum of $250 per calendar year to eligible members who meet all requirements of the program.

Program Eligibility/Requirements:

1. Reimbursement is for job-related civil service and continuing education courses, which includes courses toward a bachelor's or master's degree;
2. Courses must be offered by an accredited institution or program;
3. Test prep courses such as the GRE, GMAT, LSAT, etc. are not eligible for reimbursement;
4. Test prep courses taken to pass a test to obtain a professional license or certification, or for NYS registration (e.g. social workers), are reimbursable as long as such license, certification, or registration is a condition of employment;
5. Reimbursement will be made only after eligible member successfully completes course; or
6. If a member fails, withdraws from, or receives an incomplete in the course, that course is not eligible for reimbursement.

How to Apply for the Education Benefit

1. Submit the Education Benefit Claim Form and accompanying documentation showing that the member completed and passed the course, and payment was made in connection with the course. Among acceptable forms of documentation are bursar's receipt, financial aid statement, tuition bill indicating payment made, and transcript or other equivalent grade reports.
2. Reimbursement requests must be made no later than 120 days after the last day of the course for which reimbursement is being sought.

EMERGENCY ROOM BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse up to $150 per member, spouse, and each eligible dependent per year for emergency room visits.

How to Apply for the Emergency Room Benefit

1. Submit the Emergency Room Benefit Claim Form and Emergency Room paid receipts containing **all** of the following:
   a) Member's name and address;
   b) Patient's name and relationship to the Member;
   c) Itemization of the type of service rendered;
   d) Fee(s) charged;; and
   e) Date of the service
2. Any claim for reimbursement must be submitted to the Fund Office no later than one year from date service is rendered.

HEARING AID BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse the member, spouse, and each eligible family member up to $1,000 toward the cost of a hearing exam and hearing aid(s), and/or repairs once in each two-year period.

The Fund requires that the hearing examination be done by an Otolaryngologist, an ear, nose and throat doctor (ENT), in order to be reimbursed. A hearing examination by an Audiologist will not be accepted as an Audiologist is not usually a medical doctor. Anyone with a Master's Degree in speech and hearing may call themselves an Audiologist.

The hearing aid(s) must be prescribed by an Otolaryngologist in order to be reimbursed.

The hearing examination should consist of:

1. An Audiogram for air and bone conduction;
2. A Discrimination Test score; and
3. A Speech Reception score.

If the hearing examination reveals that hearing aid(s) will be helpful, then the Otolaryngologist should indicate the following on official documentation to the member:

1. Brand name of hearing aid(s);
2. Model of hearing aid(s);
3. Battery power of hearing aid(s); **and**
4. Frequency response of hearing aid(s)

How to Apply for the Hearing Aid Benefit

1. Submit the Hearing Aid Benefit Claim Form along with the **original itemized paid receipt** from the Otolaryngologist **and** for the purchase of the hearing aid(s), **both** of which include all of the following:
   a) Member's name and address;
   b) Patient's name, age, and relationship to member;
   c) Itemization of the type of service(s) rendered;
   d) Fee(s) charged; and
   e) Date of the service
2. Any claim for benefit payment must be submitted to the Fund Office **no later than one year from when date service or purchase is rendered**.

LEGAL SERVICES BENEFIT

MEMBER ■

The Fund provides the following legal services, at no charge to the member, unless otherwise indicated:

Estate Planning (New York State only)

- Simple & Complex Wills
- Powers of Attorney
- Healthcare Proxies
- Living Wills
- Revocable and Irrevocable Trusts
- Medicaid Planning
- Special Needs Planning (Initial Consultation free of charge; thereafter, reduced rate of $250 per hour)

Estate Administration (New York State only)

- Uncontested Probate (death with a will) for surviving family of member
- Uncontested Probate (death with a will) for surviving family if member is executor/executrix (first 10 hours covered free of charge; beyond 10 hours, reduced rate not to exceed $250 per hour)
- Simple, Uncontested Estate Administration (death without a will) for surviving family of member
- Simple, Uncontested Estate Administration (death without a will) for surviving family if member is to become the administrator of the estate (first 10 hours covered free of charge; beyond 10 hours, reduced rate not to exceed $250 per hour)
- Other Estate Administration (reduced rate not to exceed $250 per hour)

Real Estate (New York State* only)

- Purchase, Sale or Refinance of Primary Home
- Purchase, Sale or Refinance of Secondary Home
- Document Preparation and Review (in connection with covered transaction)
- Two Hours of Post-Closing Services
- Deed Transfers

  * Property must be located in NYC or Nassau, Suffolk, Westchester, Rockland, Orange, or Putnam counties (other jurisdictions may incur additional cost if Greenberg Burzichelli Greenberg accepts such retention)

Other Legal Services (New York State only)

- Name Change Petitions (Member surcharge, capped at $250)
- Civil Litigation (Reduced/Flat Rates)

How to Obtain Benefit:
Contact Law Offices of Greenberg Burzichelli Greenberg P.C., 516.570.4343

MEDICAL CO-PAY BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse up to $700 for out-of-pocket expenses the member, spouse, and/or eligible dependents incur with health care services provided by medical professionals such as doctors and at hospital visits, and at clinical laboratories, such as Quest Diagnostics.

How to Apply for the Medical Co-Pay Benefit

1. Submit the Medical Co-Pay Benefit Claim Form and a copy of invoice showing the co-pay due, that also includes the name of the doctor/hospital/laboratory at which the service was provided and the date the service was rendered.
2. Any claim for reimbursement must be submitted to the Fund Office **no later than one year from date service is rendered.**

NON-DRUG HEALTH & FITNESS REIMBURSEMENT BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse up to $300 per year for non-drug health and fitness expenses not covered by your health insurance plan as described below.

1. PPE (mask, gloves, hand sanitizer) — **MEMBER**
2. Gym, fitness club, weight loss/maintenance program (e.g. Weight Watchers) membership or attendance expenses — **MEMBER** (up to $200 of the $300 of the maximum benefit may be used for this purpose). **Excluded:** food, drinks, beverages, shakes

3. Blood pressure machine, Oximeter
4. Nebulizer
5. Adult diapers, briefs, incontinence pads for medical reasons
6. Braces, splints, supports (over the counter)

This benefit does NOT COVER the following:

1. Over-the-counter drugs
2. Personal hygiene items

How to Apply for the Non-Drug Health & Fitness Reimbursement Benefit

1. Submit the Non-Drug Health & Fitness Benefit Claim Form along with a copy of paid invoices and/or receipts showing an itemized breakdown of the purchases.
2. Members submitting reimbursement for a gym, fitness club, weight loss/maintenance program membership or attendance expenses must include a copy of their membership agreement that includes their name and dates of membership.
3. Any claim for reimbursement must be submitted to the Fund Office no later than one year from date of purchase or date membership first began.

OPTICAL BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

Each member will be reimbursed for optical expenses up to a maximum of $600 in a two-year period. Member's spouse and each eligible dependent will be reimbursed for optical expenses up to a maximum of $400 in a two-year period.

Optical expenses include frames, lenses, contact lenses, or any combination thereof prescribed by an optometrist, ophthalmologist, or physician, as well as the examination fees of those professionals.

LASIK LASER SURGERY: MEMBERS ONLY

Lasik Laser Surgery is a one-time benefit of up to a maximum of $1,500. After the elected procedure, the member no longer will be eligible for corrective lenses or eyeglasses covered under the Optical Benefit described above.

How to Apply for the Optical Benefit

1. Submit the Optical Benefit Claim Form along with a prescription for lenses, and a paid invoice for frames, lenses, contact lenses, or any combination thereof, from your optometrist, ophthalmologist, or physician.
2. You have one year from date of service to submit a claim for reimbursement.

PODIATRY BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse up to $200 per member, spouse, and eligible dependent each year for expenses incurred for visits to a Podiatrist, including any necessary x-rays.

How to Apply for the Podiatry Benefit

1. Submit the Podiatry Benefit Claim Form and all itemized bills, along with the order for the appliance from the Podiatrist containing **all** of the following:
   a) Member's name and address;
   b) Patient's name and relationship to the Member;
   c) Itemization of the type of service(s) rendered;
   d) Fee(s) charged; and
   e) Date of the service
2. Any claim for reimbursement must be submitted to the Fund Office **no later than one year from date service is rendered.**

PRESCRIPTION DRUG BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse for prescription drug expenses, as defined below, up to $2,500 per family per calendar year.

Covered Prescription Drugs

This benefit applies to prescription drugs and medications purchased from a licensed pharmacist. It does **not cover** drugs administered during hospitalization or "over-the-counter" type drugs, including but not limited to, aspirin, acetaminophen, allergy medications such as claritin and zyrtec, ibuprofen, cold tablets, cough syrup, or throat lozenges, that may be bought without a doctor's prescription.

NOTE: Most prescription drugs can be purchased under a generic brand name that has been proven to be effective and lower in cost. You should ask your doctor about substituting generic brands whenever possible.

How to Apply for the Prescription Drug Benefit

1. Submit the Prescription Drug Benefit Claim Form along with the **original pharmacy itemized receipt for each purchase** from the pharmacist, that includes **all** of the following:
   a) Name of patient;
   b) Date of purchase;
   c) Name of drug, prescription (Rx) number, and dosage;
   d) Name of prescribing physician;
   e) Cost; and
   f) Name and address of pharmacy
2. Any claim for benefit payment must be submitted to the Fund Office **no later than one year from when date service is rendered**

PROSTHETIC BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Fund will reimburse out-of-pocket expenses incurred for prosthetics up to a lifetime maximum of $2,500 per family. This includes medical wigs, mastectomy bras, breast forms, and limbs.

How to Apply for the Prosthetic Benefit

1. Complete the Prosthetic Benefit Claim Form, which can be found on our website at **www.upoa.com**
2. Submit the Claim Form and all itemized bills, proof of reimbursement from the insurance carrier, and the doctor's order for the appliance.
3. Any claim for reimbursement must be submitted to the Fund Office **no later than one year from date service is rendered.**

REHABILITATION BENEFIT

MEMBER, SPOUSE, ELIGIBLE DEPENDENTS

The Welfare Fund will reimburse for medically authorized speech and physical therapy services up to $300 per family per calendar year.

How to Apply for the Rehabilitation Benefit

1. Complete the Rehabilitation Benefit Claim Form, which can be found on our website at **www.upoa.com**
2. Submit the Claim Form, referral for such services from the referring physician, all itemized bills from the provider, and proof of reimbursement from the insurance carrier.
3. Any claim for reimbursement must be submitted to the Fund Office **no later than one year from date service is rendered.**

COBRA

What If I Lose My Benefits Coverage?

If Welfare Fund benefit coverage is lost, members and dependents may be eligible to continue to receive some or all of those benefits by paying a premium. The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, otherwise known as COBRA.

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a "qualified beneficiary." Members, spouses/domestic partners, and dependent children may become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium that is established by the Fund in accordance with Federal COBRA regulations. The maximum period of coverage ranges from 18 months to 36 months, depending on the reason for coverage loss.

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on basic Health insurance COBRA is available from City of New York. Enrolling in basic Health insurance COBRA does not assure enrollment in Welfare Fund COBRA and vice versa.

To elect COBRA you must contact the Fund Office directly at 212.226.1069 for necessary forms, available options, and costs. Upon notification, a Fund COBRA application will be mailed to you. Eligible persons choosing to elect COBRA coverage must do so within 60 days of the qualifying event or of the date on which they receive notification of their rights, whichever is later.

Member qualifying events include:

- Hours of employment are reduced to the extent plan eligibility is lost; or
- Employment is terminated for any reason other than gross misconduct.

Spouse/Domestic Partner qualifying events include:

- The member dies;
- The member's hours of employment are reduced to the extent plan eligibility is lost;
- The member's employment is terminated for any reason other than gross misconduct; or
- The member and spouse divorce or legally separate resulting in a loss of coverage.

Dependent Child qualifying events include:

- The member dies;
- The member's hours of employment are reduced to the extent plan eligibility is lost;
- The member's employment is terminated for any reason other than gross misconduct;
- The parents' divorce or legally separate resulting in a loss of coverage; or
- The child loses eligibility as a "dependent child".

Notification Responsibilities

The Fund will offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. The affected parties must notify the Fund Office within 60 days of the later of date that the qualified beneficiary would lose coverage after the qualifying event or the qualifying event itself. The Fund Office requires supporting documentation. Each person who has a qualifying COBRA event should

receive basic COBRA notice and enrollment material. Notice will include requirements for timely decisions, COBRA rates, and remittance of premium.

Responsibility to Pay Premium

The initial premium is due within 45 days of your COBRA election. Thereafter, premiums are due on the first of the month with a 30-day grace period. Since there cannot be a gap in the coverage period, coverage and premiums are retroactive to the COBRA qualifying event date. Subsequent premium payments are applied to the earliest unpaid months.

Coverage Pursuant to the Family and Medical Leave Act of 1993 ("FMLA")

Federal law provides that certain employees can take up to 12 weeks of unpaid leave in a 12-month period from City employment for certain qualifying events. Employers subject to this law may be required to keep an employee's medical coverage in force to the same extent as if no leave had been taken. You should check with the City regarding family and medical leaves.

Plan benefits are only available during FMLA leave if a Fund contribution is received from the City on your behalf for the leave period. You should contact the Fund Office for details on your coverage during any FMLA leave. Your FMLA coverage will cease once the Plan is notified or otherwise determines that you have terminated employment, exhausted your 12-week FMLA leave entitlement, or you inform the Fund of your intent not to return to employment from leave.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect continued coverage under the COBRA coverage rules. The qualifying event entitling you to COBRA coverage is the last day of your FMLA leave.

Uniformed Services Employment and Reemployment Rights Act ("USERRA")

A Plan participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. If qualified to continue coverage pursuant to USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the benefits coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of 30 days or less, the Participant may not be required to pay more than the regular contribution amount,

if any, for continuation of health coverage. A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of the Participant's absence from work; or
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues Plan benefits coverage, if the Participant returns to a position of employment, the Participant's coverage and that of the Participant's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

COORDINATION OF BENEFITS

If you or your family members are eligible to receive benefits under another group plan, benefits from UPOA/WF will be coordinated with the benefits from any of your other group plans so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans. An "allowable expense" is any necessary, reasonable, and customary expense covered in full or in part under any of the group plans involved. A "plan" is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group that provides medical or dental benefits or services on an insured or an uninsured basis.

The Fund and any insurance carrier (if applicable) reserves the right to obtain and exchange benefit information from any other insurance company, organization, or individual to determine the applicability of the Coordination of Benefits provisions. When an overpayment has been made, the Fund and the insurance carrier, if applicable, have the right to recover the excess payment from the individual, insurance company, or organizations to whom payment has been made.

In order to obtain all of the benefits available, you and your family members should file claims in the following order:

1. If you are a covered member of the Fund and are eligible for benefits from another group plan:
   a) Submit your claim to the other group plan first.
   b) After you have received payment for such claim from the other group plan, you may submit this claim to the Fund Office. You must include the Explanation of Benefits received from the other group plan.
   c) You will receive any additional benefits that may be due for this claim under the second plan, but the total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of allowable expenses.
2. If your spouse has a claim and is eligible for benefits under another group plan:
   a) Submit the claim to the other plan first.
   b) After the claim is paid by the other plan, it then may be submitted to the UPOA/WF, accompanied by a written breakdown of monies received from the other group insurance plan.
   c) Any additional benefits that may be due for the claim will be paid by the UPOA/WF, but the total amount paid for each claim from any group plan under which your spouse is eligible and from this Fund cannot exceed 100% of all allowable expenses.

3. All claims for dependent children will be paid primarily by the plan that ensures the parent whose birthday (month and day) comes first in the calendar year. However, in the event that another plan has a different Coordination of Benefits provision, the UPOA/WF Coordination of Benefit provision will be used to determine the order of payment.
4. Claims for a child whose parents are divorced when one parent is a covered member of this Fund and the other parent is a covered member of another group insurance plan should go by the following Coordination of Benefits:
   a) If the parent with custody has not remarried
      (i) First submit the claim to the plan that covers the parent with custody.
      (ii) After the claim has been paid by the first plan, then it may be submitted to the second plan, along with a written breakdown of monies received from the first plan.
   b) If the parent with custody has remarried
      (i) First submit the claim to the plan that covers the parent with custody.
      (ii) Second, submit the claim to the plan that covers the stepparent.
      (iii) Last, submit the claim to the plan that covers the parent without custody.
   c) In any event, if there is a court order that establishes financial responsibility for the medical, dental, and/or other health care expenses of the child(ren), submit the claim to the plan that covers the parent with the court-ordered responsibility first.

CLAIM APPEALS

If your claim for benefits is denied, in whole or in part, you may request a review of the denied claim within **60 calendar days** of receipt of the Notice of Denial. A claimant who has not received a decision on a claim for benefits within 90 days (or more under special circumstances) of filing may request a review, if desired, of the claim.

All appeals must be in writing, must state the basis for the appeal, and must be submitted to the Fund Office.

The Board of Trustees will review your claim at its next regularly scheduled meeting. However, if the request for a review is received less than 30 calendar days before a meeting or additional information is needed to review the appeal, then the review may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, a decision may be made at the third meeting following the date the request for review is made.

The decision of the Board of Trustees shall be in writing and shall include the specific reason(s) for the decision and specific references to Plan provisions on which the decision is based.

The decision of the Trustees is final and binding. The Trustees reserve the right to make a final and binding interpretation of the Plan, including its application. The Trustees' decision will not be made in an arbitrary and capricious manner.

RIGHT OF RECOVERY & OVERPAYMENT OF CLAIMS

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- Made in error;
- Due to a mistake in fact; or
- Due to a misstatement, a fraudulent act, or the omission of a material fact. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

RIGHT OF SUBROGATION

The right to subrogation means the Plan is substituted to and shall succeed to all legal claims that you or your dependent may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your or your dependent's behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and benefits the Plan has paid on your or your dependent's behalf relating to any sickness or injury caused by any third party.

Failure or refusal to cooperate with the Fund in making or prosecuting such claims or liens by the Fund or in making such payments to the Fund shall be sufficient reason for withholding payment of any Plan benefits.

LANGUAGE INTERPRETATION

The Trustees retain sole, full and final discretionary authority to construe and interpret the language of this Plan, to determine all questions of fact and law arising under this Plan, and to administer the Plan's subrogation and reimbursement rights.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover under the Plan unless commenced within three years from the expiration of the time within which proof of claim is required.

If any time limitation is less than that permitted by law in the State of New York, the time limit shall be extended to agree with the minimum period permitted by such law. The laws of New York State apply in all cases.

AMENDMENT OR TERMINATION OF THE PLAN

The Trustees intend to continue the Plan described in this booklet indefinitely. Nevertheless, they reserve the right (pursuant to the provisions of the Agreement and Declaration of Trust of the Fund, and any applicable provisions of a collective bargaining agreement) to amend or terminate the Plan at any time with or without prior notice. The Plan may be terminated by the Trustees when, for example, there is no longer in effect an agreement between the City and the United Probation Officers Association requiring payment to the Fund. Upon termination of the Plan, the Trustees would apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed. The Trustees have no present plans to terminate the Fund.

HIPAA STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy rules issued under the law, gives you certain rights with respect to your health information, and requires that the health benefits plan of the Fund protect the privacy of your personal health information. A complete description of your rights under HIPAA will be found in the Fund's Notice of Privacy Practices, which is provided to you when you enroll in the Fund and which will be available to anyone upon request from the Office of the Welfare Fund. The statement that follows is not intended and cannot be considered to be the Fund's Notice of Privacy Practices. Since the Fund is required to keep your health information confidential, before the Fund can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Fund, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Fund to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Fund is referred to below as "protected health information."

The Board of Trustees agrees to the following rules in connection with your protected health information:

1. The Board of Trustees understands that the Fund will disclose protected health information to the Board of Trustees only for the Trustees' use in Fund administration functions.
2. Unless it has your written permission, the Board of Trustees will use or disclose that protected health information only for Fund administration, as otherwise permitted by this Summary Plan Description, or as required by law.
3. The Board of Trustees will not disclose your protected health information to any of its agents or subcontractors unless the agents and subcontractors agree to handle your protected health information and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.
4. The Board of Trustees will allow you, through the Fund, to inspect and photocopy your protected health information, to the extent and in the manner required by HIPAA.
5. The Board of Trustees will make available to the Fund your protected health information for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA.

The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with, or on

behalf of, the Board of Trustees: the Fund Manager, the Assistant Fund Manager and all other Fund claims staff, third-party administrators, and other vendors who are routinely responsible for administration of Fund claims or advice related to the administration of claims for the Fund. Additionally, the individual Trustees may receive health information from the Fund in the course of hearing appeals or handling other Fund administrative functions. These employees and the individual Trustees will be permitted to have access to and use the protected health information only to perform Fund administrative functions that the Board of Trustees provide for the Fund.

These aforementioned employees will be subjected to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

The Board of Trustees will return to the Fund or destroy all protected health information received from the Fund when there is no longer a need for information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees will limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

United Probation Officers Association

ACTIVE WELFARE FUND
SUMMARY PLAN DESCRIPTION

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