



**UNITED PROBATION
OFFICERS ASSOCIATION
WELFARE FUND
AND
RETIREMENT WELFARE
FUND**

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KingCare, LLC

Fund Accountant

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Joel C. Glanstein, Esq.

Dear Participant:

The Trustees are pleased to issue this updated booklet which provides you with a description of your current benefits and furnishes you with other related matters for your guidance and information when filing claims. Please be aware that these benefits furnished by the Fund(s) are supplemental to your elective City health plans. To determine what coverage is available to you through the City health plans, contact your Probation Department or Union representative.

As mentioned, the booklet describes your benefits, however, it also describes your rights and responsibilities under the United Probation Officers Association Welfare and Retirement Welfare Plans. You are urged to read it carefully and to keep it available for you and your family's future reference. You are responsible for the information outlined in this booklet. Any changes in the contents of this booklet will be disseminated by mail.

While the Trustees hope that neither you nor your family experience ill health and its accompanying financial problems, it is reassuring to know that the Funds' welfare programs are available should illness or need occur.

Remember, your Fund Office, as well as the Trustees, are prepared to help you should you require assistance or information. Please be aware that the most accurate and up-to-date information is received through the Fund Office or from a member of the Board of Trustees. However, please understand that no general explanation can adequately give you all of the details of the Plans. Your rights can be determined only by referring to the full text of the Plans as contained in this booklet.

Sincerely,

THE BOARD OF TRUSTEES

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GENERAL PROVISIONS

Eligibility

The term, "Family members" shall be used throughout to describe eligible dependents, who are spouses and unmarried children under 19 years of age or between age 19 and until their 22nd birthday if they are attending a duly accredited educational institution on a full-time basis. Use the UPOA/WF enrollment form to register your dependent children. Effective January 1, 1994, benefits for domestic partners are offered on the same basis as the benefits for dependent spouses, provided the domestic partners are registered with the City of New York and the Fund Office as such.

You, your spouse and children (as described in the definition of Family Members) are eligible for benefits from the UPOA Welfare or Retirement Welfare Fund (sometimes referred to as UPOA/WF or UPOA/RWF) without cost and without medical examination, provided you are a permanent, provisional or probationary full time, active Probation Officer, Probation Officer Trainee, Supervising Probation Officer, or Senior Probation Officer (and any other covered titles) or a retiree in one of those titles. Your benefits will commence on the first day you are employed. You must complete an enrollment card and submit it to the Fund Manager. Your covered dependents will be eligible for benefits on the same day you become eligible for benefits.

An employee becomes a Participant in the Funds and remains such as an employee or retired employee for whom The City of New York is or was legally obligated to make contributions to the Funds.

If you cease to be an active employee (off staff), other than through retirement, benefits shall continue until the last day of the month in which you are an active employee.

Health benefits are continued for your dependent children between the ages of 19 and until their 22nd birthday who are attending a duly accredited educational institution on a full-time basis. Their eligibility will terminate when they are no longer a full-time student.

Benefits for any of your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond the age limit stated above if, within 31 days after the date benefits would otherwise be cancelled, you submit proof directly to the Fund Office for review of your child's incapacity. The Trustees may request or require that you submit proof of your dependent's incapacity or request that your dependent undergo an examination at any time by a physician designated by the Trustees.

Health benefits are continued for your dependent children between the ages of 19 and until their 22nd birthday who are attending a duly accredited educational institution on a full-time basis. Their eligibility will terminate when they are no longer a full-time student.

Benefits for any of your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond the age limit stated above if, within 31 days after the date benefits would otherwise be cancelled, you submit proof directly to the Fund Office for review of your child's incapacity. The Trustees may request or require that you submit proof of your dependent's incapacity or request that your dependent undergo an examination at any time by a physician designated by the Trustees.

COBRA Continuation of Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under this Plan. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you are covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

The COBRA coverage, if elected, is up to 18 months.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

The COBRA coverage, if elected, is up to 36 months.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

(See "Coverage for Your Dependents" on page 4 of the Summary Plan Description.)

The COBRA coverage, if elected, if up to 36 months.

When is COBRA Coverage Provided?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part b, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualified Events

For the other qualifying events (divorce or legal separation of the employees and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the later of (1) the date of the qualifying event or (2) the date coverage would be lost. You must provide this notice in writing to:

KingCare, LLC
375 West Broadway
New York, NY 10012

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

You and/or your dependents have up to 60 days from the later of (1) the date coverage terminated, or (2) the date on which the dependent receives notice of the right to elect coverage under COBRA in order to decide whether to elect coverage. Premium payments must be received within 45 days from the date that you elect coverage. Any election by you or your spouse is considered an election by other dependents (i.e., children) who would otherwise lose coverage by reason of the same qualifying event.

Your continuation coverage may be shorter than 18 or 36 months. For example, if

- (1) the Fund no longer provides group health coverage to any of its members;
- (2) the premium for your continuation coverage is not paid when due;
- (3) you become an employee covered under another group health plan; but if a qualified beneficiary becomes eligible for another employer's group plan that excludes a pre-existing condition, he or she must have the option to continue coverage in the prior employer's plan for the full COBRA period;
- (4) you become entitled to Medicare;
- (5) you were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 26 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two

ways in which this 18-month period of COBRA continued coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have stated at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan Administrator must be notified of the disability and be provided a copy of the Social Security disability determination within 60 days of receiving notices of the disability. The Plan Administrator must also be provided any Social Security determination that the qualified beneficiary is no longer disabled within 30 days of receipt of this notice. These should be sent to:

KingCare, LLC
375 West Broadway
New York, NY 10012

Second qualifying event extension of 18-month period of continued coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee of former employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Provide notice of a second qualifying event before the initial 18 months has expired, in writing to:

KingCare, LLC
375 West Broadway
New York, NY 10012

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage

rights should be addressed to the contact or contacts identified below. 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 nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/cbsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

UPOA Welfare Fund and UPOA Retirement Welfare Fund
375 West Broadway
New York, NY 10012

Portability of Health Coverage

Your Plan will provide you with a "Certificate of Coverage" if you lose coverage due to termination of employment or a reduction of hours at work which will be sent to you with information on the COBRA continuation program. This Certificate will be proof of coverage to be applied toward a pre-existing condition clause if you obtain coverage in another group health plan. This Plan will similarly accept such Certificate from another plan to confirm prior coverage for new participants which may be applied towards any pre-existing condition clause.

Self Pay Continuation of Coverage (COBRA)

You and/or your eligible dependents have the right to continue receiving Welfare Fund coverage on a self payment basis if coverage terminates for certain reasons. The continuation is available in the event your coverage terminates due to:

1. Termination of Employment or Reduction of Hours for any reason other than gross misconduct.
2. Termination of Employment due to retirement before age 55.
3. Your death.
4. Your legal separation or divorce.
5. Initiation of your eligibility for Medicare.
6. A dependent ceases to be covered as a dependent under this Plan.

7. Resignation for other cause.

The Employee Retirement Income Security Act of 1974 (ERISA) permits the Fund to charge any person who elects to continue coverage 102% of the full cost to the Plan. If the cost changes, the Fund will revise the charge you are required to pay, but not more than once every 12 months.

Full details of this continuation of coverage will be furnished to you or your dependents when your coverage terminates as a result of one of the events shown above.

Changes in Family Status

Dependents acquired after you submit your enrollment card as a result of marriage, adoption or birth of a child, will be covered when the Fund receives, in writing, notification of your new dependent's name, date of birth and date of marriage (if applicable). The Fund requires written notification of divorce, annulment and death of spouse or other eligible dependents and reserves the right to request written verification of changes in family status.

Timely Submission of Claims

Any claim for benefit payment, other than for a disability claim, must be submitted to the Fund Office no later than the December 31st of the year following the year in which the service is rendered. PLEASE NOTE: Reimbursement for your claims will be more timely if you submit claims immediately after the service is rendered.

COMMUNICATIONS

If You Need a Benefit Form:

- (1) Contact your UPOA delegate, Executive Board member, or a Welfare Fund Trustee, or
- (2) call the Fund Office (212)965-9393, or
- (3) call the Union Office (212)274-9950 and request a benefit form.

If You Wish to Discuss Your Coverage:

The Fund Manager and Trustees may be reached at (212)965-9393 (Please identify yourself as a UPOA/WF or UPOA/RWF member.)

The Trustees can be reached at the address and telephone number below:

KingCare, LLC
375 West Broadway
New York, NY 10012
(212)965-9393
Fax (212)-965-0890

COORDINATION OF BENEFITS

If you or your family members are eligible to receive benefits under another group plan, benefits from these Plans 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 item of 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 which provides medical or dental benefits or services on an insured or an uninsured basis.

The Welfare Funds and any insurance carrier (if applicable) reserve 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 under each plan:

- (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 which 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) He/she must submit the claim to his/her plan first.
 - b) After this claim is paid by that plan, it may be submitted to this Fund accompanied by a written breakdown of monies received from their other group insurance plan.
 - c) Any additional benefits which may be due for this claim will be paid by this Fund, but the total amount paid for each claim from any group plan under which your spouse is eligible for 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 insures 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, this plan's coordination of benefit provision will be used to determine the order of payment.
- (4) If the claim is submitted 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:
 - a) If the parent with custody has not remarried,
 - (i) submit the claim to the plan which covers the parent with custody first.
 - (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) submit the claim to the plan which covers the parent with custody first.
 - (ii) submit the claim to the plan which covers the stepparent second.
 - (iii) submit the claim to the plan which covers the parent without custody last.
 - c) In any event, if there is a court order which establishes financial responsibility for the medical, dental or other health care expenses of the child, submit the claim to the Plan which covers the parent with the court-ordered responsibility first.

SCHEDULE OF BENEFITS FOR EMPLOYEES

BENEFITS FOR YOU

Life Insurance	\$10,000
Accidental Loss of Life, Limb or Sight Insurance, up to	\$10,000
Disability Benefit (maximum 26 weeks), up to a maximum per week of	\$ 175
In-hospital Indemnity, per day up to a period of ten weeks per year	\$ 10

BENEFITS FOR YOU AND YOUR ELIGIBLE FAMILY MEMBERS

Life Insurance - Spouse.....	\$ 4,000
Dependent Children (Birth to age 19)	\$ 1,000
Dependent Children (age 19 to age 22, while in attendance at an accredited, full-time educational institution).....	\$ 1,000

Note: The employee shall be the automatic beneficiary of
the spouse and/or children.

Dental Benefit, annual maximum per person up to	\$ 3,000
Optical Benefits, maximum in a two year period per person up to.....	\$ 400
Hearing Aid Benefit, once every three years up to	\$ 700
Prescription Drug Benefit, annual maximum per family up to.....	\$ 550
Anesthesia, 80% of annual expenses per family up to an annual maximum of	\$ 500
Podiatry, annual maximum per family up to.....	\$ 200
Emergency Room Benefit, annual maximum per person up to	\$ 50
Prosthetic Appliance Benefit, lifetime maximum (Retiree & Spouse)	\$ 3,500
Hair Prosthesis, lifetime maximum (provided it is medically necessary)	\$ 250

BENEFITS FOR YOU AND YOUR SPOUSE

Comprehensive Diagnostic Examination Benefit once every year up to	\$ 200
Mammography Examination Benefit, once every year up to	\$ 70
Termination of Pregnancy Benefit, annual maximum up to	\$ 125
Vasectomy Benefit, up to	\$ 75

SCHEDULE OF BENEFITS FOR RETIREES

BENEFITS FOR YOU

Life Insurance or Burial Benefit.....	\$3,500
Rehabilitative Service Benefit, annual maximum for:	
Retired Members.....	\$ 500
Spouses.....	\$ 250

BENEFITS FOR YOU AND ELIGIBLE FAMILY MEMBERS

Prescription Drug Benefit, annual maximum per family up to	\$ 750
Dental Benefit, annual maximum per person up to	\$3,000
Hearing Aid Benefit, once every two years up to.....	\$ 700
Anesthesia 80% of annual expenses per family up to	\$ 500
Podiatry, annual maximum up to	\$ 300
Optical Benefit, maximum in a two year period per person up to	\$ 400
Emergency Room Benefit, annual maximum per person up to.....	\$ 50
Hair Prosthesis, lifetime maximum (provided it is medically necessary)	\$ 500

BENEFITS FOR YOU AND YOUR SPOUSE

In-Hospital Private Duty Nursing, 80% of expenses (for the first 72 hours) up to an annual maximum of	\$3,000
At-Home Nursing Benefit, 80% of annual expenses up to	\$3,000
In-Hospital Indemnity, per day up to a period of ten weeks per year.....	\$ 20
Prosthetic Appliances Reimbursement lifetime expenses up to	\$3,500
Comprehensive Diagnostic Examination Benefit annual maximum up to	\$ 200
Mammography Examination Benefit, annual maximum up to	\$ 150

LIFE INSURANCE

For Employees and Retirees

Death Benefit

The amount of your life insurance, as determined from the the Schedule of Benefits, will be paid to your designated beneficiary in the event of your death while insured.

Beneficiary

You may name anyone you desire as your beneficiary as well as a contingent beneficiary and you may change your beneficiary and/or your contingent beneficiary at any time. Change of beneficiary forms are available from the Fund Office. Your benefit will be paid to the individual(s) designated on the last beneficiary designation form on file at the Fund Office. **In the event that there is no beneficiary designation form on file or if there is no surviving designated beneficiary, the benefits will be paid to your estate.** Retirees may receive either the life insurance or the burial benefit only.

ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT INSURANCE

For Employees

Accidental Benefit

When you have an accident either at or away from work, and within 90 days suffer any of the losses shown below, benefits will be paid as follows:

	As Shown in the Schedule of Benefits
Loss of Life	\$10,000 (Paid to your designated beneficiary)
Loss of both hands, both feet, the sight of both eyes, or any combination of these	\$10,000 (Paid to you)
Loss of one hand, one foot, or the sight of one eye	\$5,000 (Paid to you)

Limitations and Exclusions

Benefits are not paid for losses caused directly or indirectly, wholly or partly by:

- (a) bodily or mental infirmity;
- (b) ptomaines;

- (c) bacterial infections, except which occur with and through a cut or wound at the time of the accident;
- (d) any other kind of disease;
- (e) medical or surgical treatment (except surgical treatment required by the accident and performed within 90 days after the accident);
- (f) war or any act of war; or
- (g) suicide or self-inflicted injury

WEEKLY DISABILITY INCOME BENEFIT

For Employee

Weekly Disability Income

If you become totally disabled and cannot work because of a non-occupational accident, or because of sickness not covered by Workers' Compensation, weekly income as shown in the Schedule of Benefits will be paid to you beginning on the 8th day of disability due to an accident or sickness.

Payment for any one day of disability is 1/7th of the amount of your weekly benefit.

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.

Payment Period

Weekly disability income will continue while you are unable to work up to a maximum of 26 weeks per disability.

NOTE: As per federal regulations, disability payments are subject to FICA (Social Security) deductions.

Payment Amount

You are eligible for a weekly benefit of \$175.00 for a maximum of 26 weeks.

How to Apply for the Weekly Disability Income Benefit

1. Request a United Probation Officers Association Welfare Fund disability claims form from the Fund Office. These forms will not be distributed in the work location but are available on request from the Fund Manager or Union Office.

2. In addition to requiring the completion of a claim form and medical verification of illness or injury, the Welfare Fund reserves the right to require you to submit to a medical examination, the expense of which is to be paid by the Welfare Fund.
3. In addition, for continuing benefit payments beyond 21 calendar days, you must submit further medical verification in the form of doctor's certification each three week period, or as requested.
4. **To receive payment, you MUST submit a completed disability form within 90 days of the commencement of your disability.** In addition, you MUST submit a supplemental disability claim for every 3 weeks of disability claimed thereafter for review and approval by the Trustees or their designee. Thus, if you submit your first disability form 90 days after commencement of disability, the first supplemental disability claim form will be submitted at the end of the next (fifteenth) week's period.
5. If you do not submit the required form within the time periods specified in paragraph four above, your claim for benefits may be denied.
6. If your last disability period is less than three weeks in duration, you must submit the claim form for each period not later than the end of the third week in which the disability claim existed.

DENTAL BENEFIT

For Employees, Retirees and Eligible Family Members

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 schedule on the following pages.

Deductible

There is no deductible for dental benefits.

Maximum Amount Payable

The maximum amount payable for each individual will be \$3,000 in any calendar year.

During the first 12 months that you are eligible for benefits, there is a maximum of \$750 per covered family member.

PRORATED MAXIMUM - Thereafter and through December of that year, each covered family member will be extended a prorated portion of the \$3,000 annual Dental Benefits maximum based on a percentage of time remaining in that calendar year.

Panel of Participating Dentists

When you use a UPOA Participating Dentist, you will be provided with the services listed in the Schedule of Covered Dental Expenses without any out-of-pocket expenses for 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 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 that the Participating Dentist can be paid 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 charge.

To use a Participating Dentist, select one from the List of Participating Dentists distributed to you, 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 Office. "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. The listing of a provider in this directory does not ensure that said provider will continue to participate with the Fund or that he or she will accept new patients. 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."

KingCare will monitor the costs submitted of Participating Dentists to insure that charges for services do not exceed those listed in the Welfare Fund Dental Schedule. Accordingly, you should be aware that you should not be billed except in the following few situations:

For those services that fall within the categories listed in the Schedule but which the Plan excludes from coverage (e.g. cosmetic restorations, payments in excess of plan maximums), 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 Welfare Fund Dental Schedule), you are not to pay more than the dentist's usual and customary charge for that service.

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:

for crowns, inlays, fixed bridgework and full or partial dentures, 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 which exceed Plan allowances for the Alternate Course of Treatment. Before deciding upon an alternate course of treatment, you may obtain an opinion from KingCare regarding the appropriateness of the recommended treatment.

Extension Of Benefits

A Dental Service that is completed after a person's eligibility for benefits cease 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

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 the operation 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 \$3,000. Therefore, you will be 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, 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 KingCare.

KingCare 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.

Please be aware that 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 described above) 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 \$3,000 because this Plan will not pay dental benefits in excess of that amount for an individual in one calendar year.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred for:

- cosmetic restoration

- replacement of a lost or stolen appliance
- replacement of a bridge, crown or denture which is or can be made usable according to common dental standards
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
 - (a) change vertical dimension; or
 - (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
 - (c) stabilize periodontally involved teeth; or
 - (d) provide multiple bridge abutments
- dental services that do not meet common dental standards
- services for which benefits are not payable according to the "General Limitations" section

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

for or in connection with an injury arising out of, or in the course of, any employment for wage or profit which is covered under Worker's Compensation or similar law;

for or in connection with a sickness which is covered under any disability insurance or similar law;

to the extent that they are more than Reasonable and Customary Charges;

for charges for unnecessary treatment;

to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program;

for procedures and materials not approved by the American Dental Association or the appropriate dental specialty society.

How Benefits are Paid

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. You should then complete all items in the Member Information portion. Be sure to include spouse and dependent information where applicable. If the patient is an unmarried dependent child between 19 years of age and their 22nd birthday and is attending school as a full-time student, you must include the name of the school.

Completed claim forms, with x-rays and other attachments, should be sent to KingCare.

Claim forms are available from the Fund Office, your UPOA delegate or UPOA Welfare Fund Trustee. 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 may not be reimbursed. If you would like the payment made directly to your dentist, you may do so by signing 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.

SCHEDULE OF DENTAL SERVICES

This schedule lists only a few of the hundreds of services covered. However, the Fund Office and each Trustee has a comprehensive schedule which is available for your review. "Covered Dental Expenses" will not include any dental service not provided for in the Schedule, unless the Fund Office reviews the services and accepts the expenses as Covered Dental Expenses. The Maximum Covered Dental Expense for such Dental Service will be determined by the Fund Office and will be consistent with those listed in the Schedule.

Expenses incurred for precision or semi-precision attachments, surgical implants of any type including any prosthetic device attached to them; instruction for plaque control or any hygiene, bite registrations, splinting or any dental service which does not have uniform professional endorsement will not be accepted by the Fund Office as Covered Dental Expenses.

A temporary dental service will be considered an integral part of the final dental service rather than a separate service.

DIAGNOSTIC SERVICES

	Maximum Covered Dental Expense	<u>CPT Code</u>
Examination, charting and diagnosis	\$ 22.00	110,120
maximum - one in six consecutive months		
Emergency Exam	50.00	130
Consultation with specialist	39.00	140
maximum - one in twelve consecutive months		
X-rays - maximum payment, \$40 in six consecutive months		
Intraoral film - periapical or bitewing	5.50	220
Panoramic film (in lieu of standard x-rays).....	37.40	330
Occlusal film.....	11.00	240
Temporomandibular view.....	29.70	
Anterior-Posterior view	27.50	291
Lateral view.....	27.50	292

PREVENTIVE SERVICES

Prophylaxis, including scaling and polishing maximum - one in six consecutive months		
Adult.....	\$ 33.00	1110
Child, to age 14	27.50	1120

Maximum Covered

Dental Expense
CPT Code

Topical application of sodium or stannous fluoride	14.30	1203
to age 19, maximum one application in twelve months		
Pit & fissure sealant to age 16, lifetime maximum two applications per tooth	11.00	1351
maximum per quad	27.50	1352
Space maintainer, fixed	100.10	1510
Space maintainer, removable.....	86.90	1520
Emergency visit for relief of pain	50.00	130

RESTORATIVE SERVICES

Silver amalgam filling, primary tooth one surface	22.00	2110
two surface	33.00	2120
three surface.....	45.10	2130
maximum per tooth.....	49.50	2131
Silver amalgam filling, permanent tooth one surface	33.00	2140
two surface	41.80	2150
three surface.....	53.90	2160
maximum per tooth.....	68.20	2161
Silicate or plastic, per filling	33.00	2210
Composite resin filling, one surface.....	33.00	2330
Composite resin filling, two surface	38.50	2331
Bonded resin for restoration Class IV cavities.....	70.40	2335
Reinforcement pin, per tooth.....	11.00	2951
Inlay or Onlay, one surface	110.00	2510
Inlay or Onlay, two surface	165.00	2520
Inlay or Onlay, three or more surface.....	330.00	2540
Porcelain laminate veneer	275.00	2962

CROWNS AND BRIDGES

Stainless steel crown	\$165.00	2931
Full cast crown	425.00	2790
Full cast crown with acrylic veneer	425.00	2721
Full cast crown with porcelain veneer	425.00	2752
Maryland bridge retainer, including cementation	275.00	6545
Post & core, prefabricated	100.00	2954
Post & core, cast as separate procedure	121.00	2952

Maximum Covered

Dental Expense CPT Code

Fixed bridge pontic, porcelain with metal.....	425.00	6242
Fixed bridge pontic, plastic with metal	375.00	6252
Fixed bridge pontic, any other type.....	350.00	6240
Porcelain jacket, anterior teeth only	425.00	2961
Acrylic jacket, laboratory processed	250.00	2710

ORAL SURGERY

Routine Extraction	49.50	7110
Surgical extractions	75.00	7210
Complete bony impaction.....	165.00	7240
Partial bony impaction	143.00	7230
Tissue Impaction	-0-	7220
Root resection, hemisection	104.50	3920
Removal of cyst, diameter up to 1/2 inch	77.00	7430
Removal of cyst, diameter greater than 1/2 inch.....	110.00	7431
Alveoloplasty, maximum per jaw	121.00	7320
Biopsy, excluding laboratory fees, hard tissue	46.20	
Biopsy, excluding laboratory fees, soft tissue.....	37.40	7286
Removal of labial or lingual frenum	82.50	7960
Exposure of unerupted tooth (for orthodontic purposes).....	137.50	7280
General anesthesia.....	132.00	9220
I.V. Sedation	36.30	9240

PERIODONTIC SERVICES

Periodontal root scaling, max. number per year	6	
Maximum payment per visit	\$ 66.00	4340
Tissue conditioning	33.00	5850
Rebasing or relining, laboratory process		
Subgingival curettage, bite correction, including prophylaxis per visit	33.00	4341 or 4342
full mouth maximum payment - \$120 in twelve consecutive months	66.00	4340
Surgical periodontics, per quadrant of at least five teeth		
Gingival surgery	165.00	4210
Osseous surgery,		

Maximum Covered

	<u>Dental Expense</u>	<u>CPT Code</u>
including gingival surgery.....	330.00	4260
Special periodontic appliance.....	99.00	4320
Retrograde root filling.....	38.50	3430
Vital pulpotomy, excluding final restoration	44.00	3220
Pulp cap, direct.....	16.50	3110

REPAIRS

Repairing body of broken denture.....	44.00	5510
Repair cast framework	55.00	5620
Replacing broken teeth in a denture, per tooth	27.50	5640
Reattach clasp.....	38.50	5652
Add clasp to existing partial.....	55.00	5660
Adding tooth to partial denture, first tooth	44.00	5650
Adding tooth to partial denture, additional tooth	22.00	5651
Partial denture	\$ 82.50	5760 or 5761
Complete denture	110.00	5750
Rebasing or relining, chairside		
Partial denture	52.00	
Complete denture	57.20	5230
Denture adjustment	27.50	5410
maximum - one in twelve consecutive months		
Recementing bridge.....	40.00	
Replacing or repairing facing.....	60.50	2980
Recementing crown.....	27.50	2920
Recementing inlay.....	20.90	2910

DENTURES

Complete denture, immediate	385.00	5130
Complete denture, permanent	385.00	5110
Partial denture, bilateral acrylic base	330.00	5211
Partial denture, bilateral cast metal base.....	385.00	5213
Unilateral, steel base	330.00	5281

ORTHODONTIC SERVICES

Diagnosis and initial fixed orthodontic appliances	550.00	8210
Orthodontic treatment, per month of treatment	55.00	8410
maximum - 36 months		
Prophylactic appliances for tooth guidance.....	137.50	1525
Retainer device.....	82.50	6520
Habit appliance.....	99.00	9940

Coordination of Dental Benefit

If you or your family members are eligible to receive dental benefits under another group plan in addition to the UPOA Welfare Fund Dental Plan (or if you and your spouse are both eligible employees under this Plan), benefits will be coordinated with the benefits from the other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Members should file with the primary plan first and then the secondary plan. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

For additional information on Coordination of Benefit procedures, refer to page 9.

OPTICAL BENEFITS

For Employees, Retirees, Spouses and Covered Dependents

Covered Expenses

Each member, retiree, spouse or covered dependent will be reimbursed for optical expenses incurred by you, your spouse or your covered dependents up to a maximum of \$400 in a two year period per individual.

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

How to Obtain Reimbursement

You must submit a physician's, ophthalmologist's or optometrist's prescription for lenses and a paid bill from an appropriate provider for frames and lenses, along with an Optical Benefit Reimbursement Form to the Fund Office.

COMPREHENSIVE MEDICAL EXAMINATION BENEFITS

For Employees, Retirees and Spouses of Retirees and Employees

Once every year you are entitled to a comprehensive medical examination.

How to Obtain a Comprehensive Medical Examination From the Plan Providers

To apply for this benefit, complete a "Request for a Comprehensive Physical Examination" Form and submit it to the Fund Office for authorization. It

will be returned to you, to make your appointment.

Where are Comprehensive Medical Examinations Provided?

You may receive a comprehensive exam from any of three sources:

- 1) Manhattan Internal Medicine Associates
- 2) a Health Care Now facility
- 3) a physician of your choice

IF YOU OBTAIN THE EXAMINATION THROUGH MANHATTAN INTERNAL MEDICINE ASSOCIATES, you will receive the examination at no cost to you. You will be required to provide appropriate identification to verify your eligibility. You may make an appointment at:

Manhattan Internal Medicine Associates
145 East 32nd Street
Room 303
New York, NY 10016
(212) 725-5300

IF YOU OBTAIN THE EXAMINATION THROUGH A HEALTH CARE NOW FACILITY, you will receive the examination at no cost to you. You will be required to provide appropriate identification to verify your eligibility. You may make an appointment at the following location:

Affiliated Physicians
18 East 48th Street
2nd Floor
New York, New York 10017
(212) 935-8725

IF YOU OBTAIN THE EXAMINATION THROUGH ANOTHER MEDICAL FACILITY (OR ANOTHER LICENSED PHYSICIAN), obtain a bill from the medical center or physician stating that you were provided with a comprehensive medical examination. The receipted bill must be on the medical center's or physician's stationery and indicate: the employee's (or retiree's), name, patient's name, address, a statement from the physician that a Comprehensive Medical Examination was rendered and the date of service. The United Probation Officers Association Welfare and Retirement Welfare Fund will reimburse eligible individuals up to a maximum of \$200 for a medical examination at another medical facility.

MAMMOGRAPHY EXAMINATION BENEFIT

Every year, eligible members, retirees and spouses will be entitled to a mammography (breast) examination, if authorized by their physician.

How to Obtain Benefits

You should obtain an authorization or approval from your physician and attach it to the claim form. The form must be certified by the Fund Office to determine eligibility, and will be returned to you.

Your Choice of Physician

If you obtain the examination through a licensed physician, hospital or medical center, the United Probation Officers Association Welfare Fund and Retirement Welfare Fund will reimburse you up to \$70 this is now \$150 (retirees only) toward the cost of the examination. To obtain the reimbursement, the completed claim form should be returned to the Fund Office.

The Fund has made special arrangements so that eligible participants may obtain the examination at no direct cost to them. An agreement has been made with the following specialist who will submit the completed claim form directly to the Fund Office and be reimbursed directly from the Fund. To use this service, after you receive the certified eligibility claim form from the Fund Office, you should call the physician's office set forth below to make your own appointment.

Daniel Maklansky, M.D.
1075 Park Avenue
New York, New York 10128
(212) 289-5611

PRESCRIPTION DRUG BENEFIT

For Employees, Retirees and Family Members

Prescription Drug Benefit

The Welfare Fund will reimburse employees and retirees for prescription drug expenses incurred up to \$550 (\$750 for retirees) per family per calendar year.

What Prescription Drugs are Covered

This benefit applies to prescription drugs and medications purchased from a licensed pharmacist. It does not cover drugs administered during hospitalization nor does it cover such "over the counter" type drugs as aspirin, cold tablets, cough syrup, etc. which may be bought without a doctor's prescription.

Please note that most prescription drugs can be purchased under a generic brand name which has been proven to be effective and lower in cost.

You should ask your doctor about substituting generic brands whenever possible.

How to Obtain Benefits

1. Complete the United Probation Officers Association Welfare Fund PRESCRIPTION DRUG BENEFIT CLAIM FORM.
2. Attach to the claim form an original bill for each purchase from the pharmacist, stating:
 - (a) date of purchase
 - (b) name of patient
 - (c) Prescription (Rx) number, dosage and name of drug
 - (d) name of prescribing doctor
 - (e) cost
 - (f) name and address of pharmacy
3. If needed, it will be necessary for you to obtain duplicate bills as the Welfare Fund will not return your prescription drug bills.

When to Submit Your Prescription Drug Bills

You may submit your prescription drug bills to the Fund Office at any time prior to December 31st of the year following the year in which the claim was incurred. PLEASE NOTE: Reimbursement for your claims will be more timely if you submit the claim immediately after the service is rendered.

TERMINATION OF PREGNANCY AND VASECTOMY BENEFITS

Termination of Pregnancy Benefit

For Female Employees and Spouses of Male Employees

The Fund will provide a termination of pregnancy allowance of up to \$125 for medical expenses incurred once during a twelve month period for female employees and spouses of male employees. This benefit is payable only for terminations of pregnancies performed by a licensed physician and is not payable if the termination of pregnancy is fully covered by your health plan. The covered expenses include services for miscarriages (D&C, D&E).

How to Obtain Benefits

Submit all bills with the Benefits Claim Form to the Fund Office. The receipted bill you submit must state the employee's name and address, the patient's name and relationship to the employee, itemization of the type of service rendered, the fee charged and the date of the service. Attach,

to this receipted bill, a pay stub as proof of your New York City health plan and any proof of payment from your health plan. You will not be reimbursed for bills that simply state “professional services rendered.”

VASECTOMY BENEFIT

For Male Employees and Spouses of Female Employees

The Fund will provide a Vasectomy Benefit of up to \$75 for medical expenses incurred for a male employee and spouse of a female employee. This benefit is payable only for a vasectomy performed by a licensed physician. This benefit is not payable if the vasectomy is fully covered by your Health Plan, or your spouse’s health plan.

How to Obtain Benefits

Follow the same procedure as for Termination of Pregnancy Coverage to obtain benefits for vasectomies.

HEARING AID BENEFIT

For Employee and Family Members

The Welfare Funds will reimburse employees and their eligible family members up to \$700 towards the cost of a hearing exam and hearing aid once in each two year period.

For Retired Participants

Retired participants and their spouses are entitled to a new hearing aid and exam every two years, up to a \$700 maximum.

An Otolaryngologist is an ear, nose and throat doctor. An Audiologist is not usually a medical doctor. Anyone with a Master’s Degree in speech and hearing may call himself an Audiologist. Therefore, it is required that the examination be done by an Otolaryngologist to be reimbursed.

NOTE: The Welfare Fund will not reimburse you unless your hearing aid was prescribed by an Otolaryngologist.

The hearing aid 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 test reveals that a hearing aid will be helpful, then the Otolaryngologist will indicate the brand name, model name, battery power and frequency response of the hearing aid required. A certificate or documentation to that effect should be issued to the employee by the doctor.

How to Obtain Benefits

Submit all bills with the Benefits Claim Form to the Fund Office. The receipted bills both from the Otolaryngologist and for the purchase of the hearing aid must contain the employee's or retiree's name, address, the patient's name and relationship to employee or retiree, age of patient, an itemization of the type of service rendered, the fee charged and the date of the service.

ANESTHESIA BENEFIT

For Employees, Retirees and Eligible Family Members

If you undergo surgery and require Anesthesia, the Welfare Funds will reimburse eighty (80) percent of your out-of-pocket expenses, to a maximum of \$500 a year.

How to Obtain Benefits

Submit the anesthesiologist's bill and proof of payment from your health insurance carrier, along with a Benefits Claim Form, to the Fund Office.

IN-HOSPITAL INDEMNITY BENEFIT

For Employees Only

If you are hospitalized or confined to a skilled nursing facility accredited by the Joint Commission on Accreditation of Hospitals, the Welfare Fund will pay \$10 per day for a period of up to 10 weeks. The hospital or skilled nursing facility must be staffed by licensed physicians and registered nurses 7 days/week and 24 hours/day or the in-hospital indemnity benefit will not be paid.

This benefit is independent of any disability benefits.

For Retirees and their Spouses

If you are hospitalized or confined to a skilled nursing facility accredited by the Joint Commission on Accreditation of Hospitals, the Retirement Welfare Fund will pay \$20 per day for a period of up to 10 weeks. The hospital or skilled nursing facility must be staffed by licensed physician and registered nurses 7 days/week and 24 hours/day or the in-hospital indemnity will not be paid.

How to Obtain Benefits

Submit an itemized bill from the hospital or skilled nursing facility specifying Blue Cross and/or Medicare reimbursement, along with a Benefits Claim Form, to the Fund Office.

IN-HOSPITAL PRIVATE DUTY NURSING BENEFIT

For Retirees and Their Spouses

If your medical doctor orders private duty nursing during a hospital stay, the Retirement Welfare Fund will reimburse 80 percent of your out-of-pocket expenses up to \$3,000 a year.

Nursing Care must be provided by a trained nurse (R.N. or L.P.N.) who is not a member of your immediate family or does not live with you. In addition, your doctor must certify that the care is medically necessary.

For purposes of this provision, immediate family includes the insured's father, mother, brother, sister, child(ren), stepmother, stepfather, stepchildren, aunt, uncle, great-aunt, great-uncle, grandmother, grandfather, niece or nephew.

How to Obtain Benefits

Submit copies of nurses' bills, proof of reimbursement from the insurance carrier, and the doctor's order for private duty nursing, along with a Benefits Claim Form, to the Fund Office.

AT HOME NURSING BENEFIT

For Retirees and their Spouses

If your medical doctor orders at home nursing care, the Retirement Welfare Fund will reimburse eighty (80) percent of your out-of-pocket expenses up to \$3,000 a year.

Nursing Care must be provided by a trained nurse (R.N. or L.P.N.) or a home health aide who is not a member of your immediate family or does not live with you. In addition, your doctor must certify that the care is medically necessary.

For purposes of this provision, immediate family includes the insured's father, mother, brother, sister, child(ren), stepmother, stepfather, stepchildren, aunt, uncle, great-aunt, great-uncle, grandmother, grandfather, niece or nephew.

How to Obtain Benefits

See the description discussed for the Private Duty Nursing Benefit shown above.

PROSTHETIC APPLIANCES BENEFIT

For Employees, Retirees and Spouses

If you buy or rent a prosthetic device (other than dental), the Welfare Funds will reimburse the deductible and out-of-pocket expenses incurred. There is a lifetime maximum of \$2,500, (\$3,500 for retirees).

How to Obtain Benefits

Submit itemized bills, proof of reimbursement from the insurance carrier

and the doctor's order for the appliance, along with a Benefits Claim Form, to the Fund Office.

HAIR PROSTHESIS BENEFIT

For Employees, Retirees and Spouses

If it is determined that a hair prosthesis is medically necessary, the Funds will reimburse you for out-of-pocket expenses incurred. There is a lifetime maximum of \$250. (\$500 for retirees)

How to Obtain Benefits

Submit itemized bills, proof of reimbursement from the insurance carrier and the doctor's order for the hair prosthesis, along with a Benefits Claim Form, to the Fund Office.

PODIATRY BENEFIT

Employees, Retirees and Covered Family Members

The Welfare Funds will reimburse up to \$200 (\$300 for retirees) per year for expenses incurred for visits to a podiatrist and any necessary x-rays. Orthotic devices may be reimbursed once in a lifetime. No benefits will be paid for orthotics or surgery if expenses are fully covered by your New York City health plan.

How to Obtain Benefits

The receipted bills from the Podiatrist that you submit to the Fund Office must contain the Participant's name, address, the patient's name and relationship to the Participant, an itemization of the type of service rendered, the fee charged and the date of the service.

EMERGENCY ROOM BENEFIT

Employees, Retirees and Covered Family Members

The Welfare Funds will reimburse up to \$25 bi-annually for emergency room visits.

REHABILITATIVE SERVICE BENEFIT

Retirees

The Retirement Welfare Fund will reimburse you for medically authorized speech and physical therapy services, up to \$500 a year for retired members and their spouses.

How to Obtain Benefits

To be reimbursed for this benefit, you must submit (1) your receipts

from the professional provider, (2) the referral for such services from the referring physician and (3) an Explanation of Benefits with your claim to determine that the claim had not been previously reimbursed under the City's Basic Health Plan. This information should be submitted, along with a Benefits Claim Form, to the Fund Office.

GENERAL LIMITATIONS

No benefits will be paid for expenses incurred:

1. for occupational accidents or sickness covered by Workers' Compensation;
2. for any expenses that are in any way reimbursable through any public program, including Medicare;
3. for confinement in, or treatment received from, a hospital owned or operated by the United States government, unless there is a legal obligation to pay such charges without regard to the existence of any insurance;
4. for charges which you or your family members are not legally required to pay;
5. for charges which would not have been made had insurance coverage not existed;
6. for charges in excess of what is reasonable and customary for the locality in which they are incurred;
7. for any other unnecessary care or treatment;
8. for payment under this Plan that is prohibited by any law to which you or your family member is subject at the time expenses are incurred;
9. for benefits otherwise payable under Coordination of Benefits with another group health insurance plan;

PLAN TERMINATION OR AMENDMENT

The Trustees intend to continue the Plan described in this booklet indefinitely. Nevertheless, they expressly reserve the right, subject to the provisions of any pertinent collective bargaining agreement, to terminate or amend the Plan. Among other reasons, the Plan may be terminated by the Trustees when there is no longer in effect an agreement between an Employer and the Union requiring payment to the Fund. Upon termination of the Plan, the Trustees will apply the monies of the Fund to provide benefits or otherwise to carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed, subject to reasonable and necessary expense incurred in winding up the legal affairs of the Welfare Fund or Retirement Welfare Fund.

APPEAL PROCEDURE

If a person files a claim for benefits and the claim or payment of the benefits is wholly or partially denied, the Fund Manager shall, within ninety (90) days of the date the claim for benefits was filed, provide notice in writing to such claimant setting forth the specific reason or reasons for denying payment of the benefits, which reasons shall be stated in as clear a manner as possible and in a fashion calculated to be understood by the claimant. If special circumstances require additional time for processing the claim, written notice of this extension of time shall be sent to the claimant within the ninety (90) day period. Such extension shall not exceed one hundred and eighty (180) days from the date the claim was filed.

Any notice sent by the Fund Manager denying, in whole or in part, any claim, shall also make reference to the specific and pertinent provisions of the Funds' Benefit Booklet, as amended, if any, upon which the denial is based, and, if appropriate, shall describe any additional material or information necessary for the claim to be honored along with an explanation of why such material or information is necessary. Such notice shall also include a statement that the claimant has a right within sixty (60) days of written notification of the denial of the claim, in whole or in part, to request in writing a review by the Trustees of the decision denying the claim.

All such appeals or requests for review of the Fund Manager's decision denying in whole, or in part, any claim, shall be referred by the Fund Manager to the Chairperson of the Board of Trustees. If the request for review is made within thirty (30) days prior to a scheduled meeting of the Trustees, the claim shall be referred to the Trustees for determination. If the request for review or appeal is filed within sixty (60) days prior to a scheduled meeting of the Trustees, the appeal or request for review may be referred by the Chairperson to two Trustees, who shall be delegated to hear and determine the appeal.

A decision on a request for review or appeal shall be made within sixty (60) days after the Fund Manager's receipt of a request for review, unless special circumstances require an

extension of time for the processing of the claim for review. In such event, a decision shall be rendered as soon as possible, but not later than one hundred twenty days after receipt of the request for review. Written notice of the extension of time for making a decision on the request for review shall be furnished to the claimant prior to the extension.

The decision of the Trustees, or the two Trustees to whom is delegated the authority to reach a decision on an appeal or request for review, shall be in writing and shall be final and shall provide reasons for the denial or grant of the claim and specific references to the provisions of the Funds' Benefit Booklet, as amended, if any, upon which the decision is based.

Any claimant, or representative thereof filing an appeal or request for

review shall have the right to appear in person before the Trustees, or the Trustees who have been delegated authority to reach a decision or determination on the appeal. The Trustees hearing the appeal will consider the evidence presented and will listen to argument for a reasonable period of time in considering the appeal.

SUBROGATION

If this Fund makes payment to or for the benefit of a covered member or eligible dependent it shall have the primary right to make and prosecute claims which such covered member or dependent may have against third parties and to reimburse itself for the full amount of benefits it paid out as a result of the complained of conduct of such third parties. Any excess recovered will be paid over to the covered member or dependent. In the event recovery is made against third parties by such covered employee or dependent, by suit or otherwise, the Fund shall be fully reimbursed and, to that end, shall have a lien against such proceeds in such amount. Failure or refusal to cooperate with the Fund in making or prosecution such claims or liens by the Fund or in making such payments to the Fund shall be sufficient reason for withholding payment of any Funds benefits.

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 to terminate or amend 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 an Employer and the 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.

CLAIMS REVIEW PROCEDURE

A member who has received a notice that his/her claim has been denied may request a review of the denied claim within 60 days of the receipt of the notice of denial. A claimant who has not received a decision on a claim for benefits within 90 days of filing (or 180 in special circumstances) may request a review, if desired, of the claim. A claimant, or his/her authorized representative may request a review, may have the opportunity to review pertinent documents, and may submit issues and comments for writing. Request for review must be made in writing and should be sent to the Fund Office.

The Board of Trustees will review your claim at its next regular

scheduled meeting. However, if the request for a review is received less than 30 days before a meeting 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 a 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. When you request a review of a denied claim you will be notified of approximate date you can expect to receive a decision.

The Trustees reserve the right to make a final and binding interpretation of this plan, including its application, which, however, will not be made in an arbitrary and capricious manner.

BOARD OF TRUSTEES 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 UPOA Welfare Fund (referred to below as the “Plan”) protect the privacy of your personal health information. A complete description of your rights under HIPAA will be found in the Plan’s Notice of Privacy Practices, which must be distributed to all Plan participants by April 14, 2004 (or when you enroll in the Plan, if you enroll after April 14, 2004) 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 Plan’s Notice of Privacy Practices.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, 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 Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan is referred to below as “protected health information.” Before the Plan provides your protected health information to the Board of Trustees, the Trustees must certify that Plan documents have been changed to include the following language set forth below.

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

The Board of Trustees understands that the Plan will disclose protected health information to the Board of Trustees only for the Trustees’ use in plan administration functions.

Unless has your written permission, the Board of Trustees will use or

disclose that protected health information only for plan administration, as otherwise permitted by this Summary Plan Description, or as required by law.

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.

The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission.

The Board of Trustees will report to the Plan's Privacy Officer if the Trustees become aware of any use or disclosure of protected health information that is inconsistent with the provisions set forth in this Summary Plan Description.

The Board of Trustees will allow you, through the Plan, to inspect and photocopy your protected health information, to the extent; and in the manner, required by HIPAA.

The Board of Trustees will make available to the Plan your protected health information for amendment and incorporation of any such amendments to the extent, and in the manner required by HIPAA.

The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that it may make available to the Plan the information required for the Plan to provide an accounting of certain types of disclosures of protected health information.

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 the Board of Trustees: the Fund Manager, the Assistant Fund Manager and all other Welfare Fund claims staff routinely responsible for administration of Plan claims for the Plan. Additionally, the individual Trustees may receive health information from the Plan in the course of hearing appeals or handling other Plan administration functions. These employees and the individual Trustees will be permitted to have access to and use the protected health information only to perform the Plan administration functions that the Board of Trustees provide for the Plan.

These employees listed above 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 Plan's Privacy Officer and will cooperate with the Plan 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 Plan or destroy all protected health information received from the Plan 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.

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