LOCAL 300 - SEIU - AFL-CIO CIVIL SERVICE FORUM

SERVICE EMPLOYEES INTERNATIONAL UNION WELFARE FUND

ACTIVE EMPLOYEES WELFARE FUND

BENEFITS BOOKLET

SEPTEMBER 2015
LOCAL 300 - SEIU - AFL-CIO
CIVIL SERVICE FORUM EMPLOYEES WELFARE FUND

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BENEFITS AT A GLANCE

PRESCRIPTION DRUGS: NO ANNUAL LIMIT

Generic Drugs At Preferred Pharmacies
- $10 co-pay for 30-day supply
- $20 co-pay for 60-day supply
- $30 co-pay for 90-day supply

Generic Drugs at Non-Preferred Pharmacies
- $15 co-pay for 30-day supply
- $30 co-pay for 60-day supply
- $45 co-pay for 90-day supply

Brand Drugs at Preferred Pharmacies
- 30% or minimum of $70 co-pay for 30-day supply
- 30% or minimum of $140 co-pay for 60-day supply
- 30% or minimum of $210 co-pay for 90-day supply

Brand Drugs at Non-Preferred Pharmacies
- 50% or minimum of $75 co-pay for 30-day supply
- 50% or minimum of $150 co-pay for 60-day supply
- 50% or minimum of $225 co-pay for 90-day supply

Health Centers
No Co-pays

DENTAL: $2,500.00 yearly MAXIMUM per calendar year
ORTHODONTIC: $2,300.00 (children under 19)
OPTICAL: $200.00 per calendar year
PODIATRY: $200.00 per calendar year
HEARING AID: $500.00 per ear once every 3 years

DEATH BENEFIT:
- $20,000 for death of a member’s up to age 62
- $5,000 for age 62 and above
- $500 for death of a member’s covered spouse

DISABILITY: $100.00 per week up to 18 weeks within 24 months (must be an active member for at least two years)

LEGAL SERVICES: Call Union Office for appointment
Are You Eligible For Coverage Under This Fund?

WHO IS ELIGIBLE?

1. All Active full time per annum employees and full time per diem on active pay status in a title for which contributions are paid by the City of New York or other qualified employers to the Civil Service Forum Local 300 SEIU AFL-CIO Employees Welfare Fund.

2. Part time employees on active pay status in a title for which contributions by the City of New York or other qualified employers to the Civil Service Forum Local 300 SEIU AFL-CIO Employees Welfare Fund. These employees will be eligible for part time (50%) benefits only.

WHEN DO YOU BECOME ELIGIBLE FOR THE WELFARE FUND BENEFITS?

You become a "COVERED MEMBER", eligible for the full range of benefits offered by the Civil Service Forum Local 300 SEIU AFL-CIO Employees Welfare Fund on the first day of the month after you have completed 90 days of employment as a new employee. If you were previously covered under another municipal welfare fund immediately before entering this Fund, the waiting period does not apply. If you are granted a Special Leave of Absence by your employer and the Fund does not receive a contribution on your behalf during that leave period, you are not covered for Fund benefits but may be entitled to continue benefits provided you pay for same.

WHEN DOES YOUR ELIGIBILITY TERMINATE?

All benefits terminate at the end of the first month for which no contributions are received by the Fund from a participating employer on your behalf.

MAY I DECLINE COVERAGE?

You may decline coverage of Fund benefits for you and/or any enrolled dependents at any time by completing a declination form, which can be obtained from the Fund office. Since Fund benefits are funded exclusively by collectively bargained employer contributions, you will not receive a rebate or any other compensation if you decline benefits for yourself and/or any eligible dependent(s).

WHAT HAPPENS IF YOU LOSE ELIGIBILITY AND ARE THEN REINSTATED?

If your benefits were terminated you will be considered a "new" employee. You will again become eligible according to the requirements set forth in the section entitled "When Do You Become Eligible For The Welfare Fund Benefits?"
WHO IS AN ELIGIBLE DEPENDENT?

Your dependents or your lawful spouse or domestic partner and each unmarried child up to their 19th birthday. "Child" is defined as a natural child, stepchild or adopted child (including those placed during the waiting period), provided such child is dependent upon you for support and maintenance, and proof of such (i.e. adoption papers and/or a 1040 tax form) is provided to the Fund Office. Coverage for a dependent child may be continued up to age 23 if he or she is a full time student in an accredited educational institution and proof of such in the form of an official transcript is provided to the Fund Office, each semester. Failure to submit evidence of student eligibility will result in a suspension or termination of benefits until documentation is received by the Fund. In addition, dependent children whose eligibility would otherwise terminate solely due to attainment of age nineteen shall continue to be considered eligible dependents while they are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, provided written evidence of such incapacity is furnished to the Fund, with respect to any such child, within 31 days after attainment of age nineteen. The incapacity must have existed prior to their attainment of age nineteen and such children must reside with a covered member. Proof of continued incapacity shall be furnished to the Fund at its request.

**Note:** Coverage for prescription drug benefits only will continue for all children until their 26th birthday, regardless of whether the child is dependent on you for support or a full time student.

A 'domestic partner' is defined as any individual, eighteen years of age or older, who is not married or related by blood to the member in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with the member, who lives with the member and has been living with same on a continuous basis, and who, together with the member, has registered as a domestic partner of the member and has not terminated the domestic partnership. Members can obtain details concerning eligibility, enrollment and tax consequences from the New York City Office of Labor Relations Domestic Partnership Liaison Unit 212-306-7336.

When enrolling or changing dependents, the member must attach certified copies of necessary documents to the Enrollment Card (such as birth certificate, marriage certificate, adoption papers, divorce judgment or separation agreement, etc.). The Fund reserves the right to request additional documents verifying the bona fide relationship of any dependents to a member.

To establish eligibility of a member's stepchild, the member must submit proof that the step-child is covered through the member's City provided basic health coverage or an affidavit verifying that the child resides full time with the member and proof of financial dependency as shown by income tax records. This affidavit is available at the Fund Office.
What Happens If There Is a Change in your Family Status?

It is important that you notify the Fund Office as soon as possible of any change in your family status (marriage, divorce, separation, termination of a domestic partnership, birth or adoption of a child, death of an eligible dependent) and of any change of address. Failure to do so could result in loss or delay of benefits. If you fail to timely notify the Fund office of a divorce or termination of a domestic partnership and your former spouse/domestic partner incurs claims paid by the Fund, you will be held financially responsible for repayment of those claims to the Fund. It is important and to your advantage that you keep the Fund up-to-date on your current status.

CONTINUATION OF COVERAGE (COBRA)

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan of the SEIU Local 300 Civil Services Employees Welfare Fund (“Fund”) and under federal law, you should contact the Fund Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. The Fund cannot represent whether or not the type of benefits coverage it provides will be available through the Health Insurance Marketplace.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of health benefits coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this section. 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 Fund’s Plan is lost because of the qualifying event. Under the Fund’s Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage of the following Fund benefits:

- Prescription Drug
- Dental
- Optical
- Hearing Aid
- Podiatry
If you’re a Fund member, you’ll become a qualified beneficiary if you lose your coverage under its Plan because of the following qualifying events:

- Your hours of employment with the City of New York are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of a member, you’ll become a qualified beneficiary if you lose your coverage under the Fund’s Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment with the City of New York 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.

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

- The parent-employee dies;
- The parent-employee’s hours of employment with the City of New York 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 (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund’s Plan as a “dependent child.”

**When is COBRA continuation coverage available?**

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. The employer must notify the Fund of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Fund within 60 days. You must provide this notice to the Fund Office.
How is COBRA continuation coverage provided?

Once the Fund 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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Fund’s Plan is determined by Social Security to be disabled and you notify the Fund in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started 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 COBRA continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 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 the Fund is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the member or former member dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Fund’s Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. The Fund cannot represent whether or not the type of benefits coverage it provides will be available through the Health Insurance Marketplace.

How are COBRA Continuation Coverage Rates Determined?

The law 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. In addition, if the benefits change for active employees your coverage will change as well.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (ELSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). If you take a FMLA leave, your employer must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. However, if you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage during your leave unless you do not return because of a serious health condition of yourself or a family member or other circumstances beyond your control.

If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation coverage.

Contact the Fund Administrator for more information about your rights and your dependents’ rights to continuation coverage.
Privacy of Protected Health Information Under the Health Insurance Portability and Accountability Act (“HIPAA”)

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the Fund to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund’s privacy notice, which is distributed to all new members upon enrollment, a copy of which is available from the Fund Office.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe HIPAA’s privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Coordination of Benefits

WHAT IS COORDINATION OF BENEFITS?

When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all Group Plans will not exceed 100% of the total amounts charged. Members and their spouses or domestic partners who are also members of this Fund may only receive benefits hereunder as the member. They may not receive benefits as the dependents of the other member. Likewise, their dependents may receive benefits under one of the member’s coverage, pursuant to the "birthday rule" for coordination of benefits.

HOW DOES COORDINATION OF BENEFITS WORK?

If you are a covered member of the Fund and are eligible for benefits from another group plan:

• Submit your claim to the Local 300 SEIU Welfare Fund office.

• After you have received payment from the Fund, you may submit claim for the unpaid balance to the other group plan under which you are eligible for benefits.

• You will receive any additional benefits, which may be due for this claim under the second plan.
• The total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged.

• If your spouse has a claim and is eligible for benefits under another group plan:
  • Your spouse must submit a claim to his or her plan first.
  • After the claim is paid by your spouse's plan, a claim for the unpaid balance may be submitted to this fund along with an explanation of benefits received from the other plan.
  • Any additional benefits which may be due for this claim will be paid by this Fund.
  • 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 the total amount charged.

• If a claim is submitted for a child when one parent is a covered member of the Fund and the other parent is a covered member of another plan:
  • Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in the calendar year.
  • After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.
  • The payment you receive for each claim from both plans cannot exceed 100% of the total amount charged.

If the claim is submitted for a child whose parents are divorced when one parent is a covered member of the Fund and the other parent is a covered member of another plan:
• If the parent with custody has not remarried,
  • submit the claim to the plan which covers the parent with custody first.
  • after the claim has been paid by the first plan then it may be submitted to the second plan along with an explanation of benefits from the first plan.
• If the parent with custody has remarried,
submit the claim to the plan which covers the parent with custody first.

submit the claim to the plan which covers the stepparent second.

submit the claim to the plan which covers the parent without custody last.

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. A copy of such court order must be submitted with your claim.

WHAT ARE MY RIGHTS OF APPEAL?

The Fund Office uniformly applies all rules. The action of the Fund Office is subject only to review by the Board of Trustees. An appeal must be filed with the Fund Office within sixty- (60) days of denial of the claim, by submitting notice in writing to the Board of Trustees, SEIU Local 300 Civil Services Welfare Fund, 36-36 33rd Street Long Island City, New York 11106. The appeal must contain reasons supporting why a decision should be overturned. Supporting documentation should also be submitted. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final, conclusive, and binding on all persons.

OVERPAYMENT/FUTURE OFFSET

In the event you receive an overpayment of Welfare Fund benefits, on your behalf or on behalf of your dependent, you are obligated to refund this overpayment to the Fund immediately. In the event you fail to refund this overpayment, the Fund can offset the overpayment against future benefits until the overpayment is fully recouped, or suspend your benefits, as well as those of your eligible dependents, until the said overpayment is paid in full. Such offset and/or suspension can be applied to the member's and eligible dependents' benefits. An overpayment includes, but is not limited to, any payment made on claims submitted by individuals who are no longer eligible for benefits (i.e., divorced spouse of a member who did not elect to continue coverage under COBRA) as well as a payment of the wrong amount on a claim.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled – to the extent it pays out benefits – to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:
To reimburse the Fund, to the extent of benefits paid by it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise; and

To take all reasonable steps to effect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement.

**AMENDMENT OR TERMINATION OF BENEFITS**

This booklet and amendments constitute the plan of benefits for members provided by the SEIU Local 300 Civil Service Forum Employees Welfare Fund and, as such, include the specific terms and conditions governing the coverage and the benefits provided for members by the Fund. In addition, there are various administrative policies and procedures that are applied on a uniform basis by the Fund, and claimants will be informed whenever such policies and procedures are applied.

The SEIU Local 300 Civil Services Forum Employees Welfare Fund is maintained for the exclusive benefit of employees of New York City who are “covered” under agreements with the SEIU Local 300 Civil Services Forum, and for whom the employer contributes monies to the Welfare Fund and any other employee who is covered by a collective bargaining agreement under which the employer makes a contribution to the Welfare Fund. However, the Fund reserves its rights, under applicable law, to alter and/or terminate the plan of benefits, as it currently exists.

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees, in its sole discretion. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust indenture that established the Fund and governs its operations.

Your coverage and your dependent’s coverage will stop on the earliest of the following dates:

- When you are no longer eligible; or
- When the employer ceases to make contributions on your behalf to the Fund; or
  - When the Fund is terminated.

Your dependent’s coverage will also terminate on the date when they longer meet the definition of “eligible dependent.”

Member benefits under this plan have been made available by the Trustees as a privilege and not as a right and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. The Trustees may expand, modify or cancel the benefits for members; change eligibility requirements and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.
COMPREHENSIVE DENTAL EXPENSE BENEFITS

WHO IS ELIGIBLE?

Covered Members and their Eligible Dependents.

HOW DO COMPREHENSIVE DENTAL EXPENSE BENEFITS WORK?

Comprehensive Dental Expense Benefits provide scheduled reimbursement for preventive, basic and major non-orthodontic dental expenses with no deductible requirement. Benefits are also provided for orthodontic services up to Plan maximums.

THE SCHEDULE OF BENEFITS

Your Comprehensive Dental Expense Benefits pay a set amount for covered expenses you have for preventive, basic, and major dental services up to a maximum benefit of $2,500 per year for each covered person. The dental year runs from January 1 to December 31. A summary fee schedule of the more frequently used dental procedures is available on the Union/Fund website at www.local300csf.org.

Orthodontic Benefit

HOW DOES THE ORTHODONTIC BENEFIT WORK?

Orthodontic services are reimbursed according to a fee schedule up to a LIFETIME MAXIMUM of $2,300. A PERIOD OF ORTHODONTIC TREATMENT starts on the first day your dependent has a covered expense for orthodontia and extends for a period of 24 consecutive months or less if the treatment is completed in less time. The orthodontic benefit is NOT included in the yearly dental maximum.

WHO IS ELIGIBLE FOR THE ORTHODONTIC BENEFIT?

Eligible dependents only up to their 19th birthday.

WHAT ARE COVERED ORTHODONTIC EXPENSES?

- The diagnosis and insertion of the initial appliance: Up to $500 (this includes all work up fees).

- $75 per active monthly visit with a maximum of 24 consecutive visits. If your dependent misses a monthly visit, the Fund will not reimburse for that month but it will be counted towards the 24 consecutive visits.
WHAT IS PRE-AUTHORIZATION?

When a dentist's charges for a course of treatment will amount to $500 OR MORE, dental services must be authorized by the Fund before treatment is provided. Pre-authorization by the Fund's dental consultant is required for any proposed course of treatment in which a dentist's charges will amount to $500 or more. X-rays must be included with treatment plans submitted for pre-authorization. Pre-authorization by the Fund's dental consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the dental plan, nor is it a determination of the patient's eligibility or of the amount to be paid under the Fund's dental schedule.

The covered member's or eligible dependent's dentist is required to submit x-rays and a treatment plan to the Fund Office for review by the Fund's dental consultant no later than 30 days after the initial examination. A claim submitted for pre-authorization will be returned to the dentist indicating the pre-authorization decision. Your dentist should contact you upon receipt of the claim form.

The dentist may proceed to provide dental services as soon as the treatment plan has been authorized by the Fund. The Fund reserves the right to modify or deny payment of claims amounting to $500 or more which have not been approved by the Fund before the beginning of treatment.

HOW DO YOU SUBMIT A CLAIM?

Claim forms are available at the Fund office. The forms themselves provide instructions concerning proper filing. When you have a claim, you should promptly submit the completed claim form and all bills and receipts. Claims submitted after 90 days after completion of dental services will be denied.

It may become necessary to require additional proof or information concerning a particular claim, and so we reserve the right to require such proof or information, including but not limited to any or all of the following:

- A dental chart showing work done before the treatment for which claim is made.
- X-rays, lab or hospital reports.
- Cast molds or other evidence of the dental condition or treatment.
- Post-treatment examination of the patient, at the Fund's expense, by a dentist it selects.
WHAT IS AN ALTERNATE BENEFIT PROVISION?

When more than one dental service would provide suitable treatment, your benefits will be based on the treatment determined by the Plan to be best suited to your condition by accepted standards of dental practice. If two services would both provide satisfactory results according to accepted standards of dental practice and one service is less expensive than the other, the Plan will reimburse up to the reasonable and usual charge for the less expensive treatment.

WHAT IS THE PARTICIPATING PROVIDER OPTION?

Participating Providers are dental care providers who have agreed to provide covered dental procedures at NO OUT-OF-POCKET EXPENSE to Fund members and their eligible dependents.

The Fund does not recommend the services of any particular provider. We have selected participants in the dental care panel because they have agreed to accept the Fund's fee schedule as PAYMENT IN FULL FOR COVERED SERVICES. In addition, we have sought out providers who have treated Fund members in the past.

Please remember that Fund members and their dependents are still subject to annual and lifetime coverage limits as specified in the dental plan description. The only time that you will have to make a payment is for procedures that are not covered and for procedures performed after you have reached the plan maximum.

If, for any reason you encounter any irregularity or trouble with the services provided by a participating dentist, please contact our dental plan administrator, Daniel H. Cook Associates, Inc., at (212) 505-5050.

Contact the administrator also, if you are charged for any covered service. DO NOT PAY ANY SUCH CHARGE.

A listing of all the Panel dentists will be provided to you by the Fund Office.

DENTAL IMPLANTS

Dental Implants are devices specially designed to be placed within or on the upper or lower jaws as a means of providing an anchor for replacement of ones teeth.

The Fund provides a lifetime maximum for implants of $2,000 per eligible participant, with a maximum allowance of $1,000 per implant, not to be included in the annual dental maximum. All other dental procedures such as crowns, pontics and dentures relating to the implant will be paid according to the Fund's current fee schedule and will be included in the annual dental maximum.
Benefits Not Covered:

- fixed bridgework or dentures to replace teeth that were missing before the date you or your dependents became covered under this Plan,
- treatment from anyone other than a licensed dentist or physician, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician,
- facings, veneers, or similar material placed on molar crowns or pontics,
- services performed by a member of your or your spouse's immediate family, unless proof of payment is provided for those services,
- services or supplies that are cosmetic in nature or directed toward a cosmetic end,
- any service or supplies incurred, installed, or delivered before you or your dependents become eligible for benefits under this Plan,
- replacing a lost, missing or stolen prosthetic appliance,
- a broken appointment,
- any services received from a medical department, clinic or any facility provided or furnished by your or your dependent's employer,
- any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist,
- services or supplies that do not meet accepted standards of dental practice including experimental services or supplies
- services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared,
- any duplicate prosthetic appliance except as specifically provided,
- completing claim forms,
- oral hygiene, or dietary instruction or plaque control programs,
- implants
- wiring or bonding teeth or crowns to act as a splint for any reason,
- an injury arising from employment,
- illness covered by Workers' Compensation,
- services or supplies for which you are not required to pay,
- appliances, restorations, or any procedure to alter vertical dimension for cosmetic purposes,
- services or supplies not specifically listed under covered expenses,
- the Fund will not pay any benefits that are covered by the New York State or other jurisdiction's No-Fault Insurance Law.
Prescription Drug Benefits

WHO IS ELIGIBLE?

All covered members and their eligible dependents are entitled to this benefit. Eligible dependents are defined at page 8 of this booklet.

WHAT IS THE BENEFIT?

This is a self-insured benefit provided by the Fund and administered by General Prescription Programs. Every covered member is issued a prescription drug card which will certify the member’s and their dependents’ eligibility to participating pharmacies.

The Fund has no annual dollar limit on prescription drug expenses. For the 2015 Plan Year, members with individual coverage have a $6,850 annual out-of-pocket maximum and members with family coverage will have a $13,700 annual out-of-pocket maximum. (These permitted out-of-pocket maximums are subject to change each year in accordance with the Federal Patient Protection and Affordable Care Act.) To be covered by the Fund’s Plan, prescription drugs must be prescribed by a doctor, dentist or physician licensed in the State in which the treatment is given and dispensed under the Rx number of a licensed pharmacist. This benefit covers:

- Prescriptions which require compounding.
- Prescriptions which require legend drugs (drugs which by law cannot be dispensed by a pharmacy without a prescription).

WHAT IS NOT COVERED BY THIS BENEFIT?

- Prescriptions may not exceed a 30-day supply unless a refill is authorized by the doctor.
- Drugs which may be purchased without a prescription are not covered (even if prescribed and dispensed in the manner outlined above).
- Allergens, antigens and other prescription drugs purchased from a laboratory or physician directly are not covered.
- The cigarette patch.
• **Specialty Drugs** – The Fund’s Plan does not cover “specialty drugs” (defined by the New York State Department of Health), which are high cost drugs used to treat acute and chronic conditions (including, but not limited to, Rheumatoid Arthritis, Multiple Sclerosis, Cancer, Growth Deficiency, Respiratory Conditions and Hepatitis C). These drugs often require special handling, can be self-administered or administered by a health care provider in the home when appropriate or in a practitioner’s office. Specialty drugs are often associated with complex medical regimes and require patient education, monitoring and clinical support. Generic substitutes or brand name therapeutic equivalents for specialty drugs are generally unavailable. The Federal Centers for Medicare and Medicaid Services (“CMS”) define specialty drugs as those that cost more than $600 per month.

The Fund’s Board Trustees retains the sole right, in its own discretion, to determine whether a drug is deemed a specialty medication. Any such determination by the Trustees will be made in consultation with the Fund’s prescription benefit manager and benefits consultants.

Many specialty medications are covered by the City’s basic health plans and PICA drug program, which covers Injectable and Chemotherapy drugs. In addition, manufacturers’ patient assistance programs are available for those in need of coverage.

**WHAT OPTIONS ARE AVAILABLE TO YOU UNDER THIS BENEFIT?**

Under this benefit you have the following options to fill your prescriptions:

**A. Preferred Retail Pharmacies**

The Fund has made arrangements with a network of preferred retail pharmacies who will fill prescriptions for generic and brand name drugs subject to the following reduced member co-payments:

- **Generic Drugs**
  - $10 co-pay for 30-day supply
  - $20 co-pay for 60-day supply
  - **$30 co-pay for 90-day supply**

- **Brand Drugs at Preferred Pharmacies**
  - 30% or minimum of $70 co-pay for 30-day supply
  - 30% or minimum of $140 co-pay for 60-day supply
  - 30% or minimum of $210 co-pay for 90-day supply

**B. Non-preferred Retail Pharmacies**

You may fill your prescriptions at any other retail pharmacy subject to the following member co-payments

- **Generic Drugs**
  - $15 co-pay for 30-day supply
  - $30 co-pay for 60-day supply
  - $45 co-pay for 90-day supply
• **Brand Drugs**
  50% or minimum of $75 co-pay for 30-day supply
  50% or minimum of $150 co-pay for 60-day supply
  50% or minimum of $225 co-pay for 30-day supply

C. **Health Centers/Mail Order**
The Fund’s prescription benefit manager has made arrangements with a network of special Health Centers through which you may purchase your prescription drugs through Olshin’s Pharmacy, the Fund’s mail order pharmacy program. There will be no cost (i.e. no co-pay) to the member or an eligible dependent if this process is used. An explanation and locations of these Health Centers will be at the end of this section.

To Purchase your prescription drugs through a Health Center, you must receive a physical examination from one of their attending physicians who will then prescribe your medication. You may be responsible for small co-payment to the Health Center for the physical examination. Be sure to tell the physician to send your prescription(s) to OLSHIN’S Pharmacy.

The following are the Health Centers participate in this program:

**ODA PRIMARY HEALTH CARE NETWORK**
14-16 HEYWARD STREET
BROOKLYN, NY 11249
718-260-4600

**ODA PRIMARY HEALTH CARE CENTER, INC.**
420 BROADWAY
BROOKLYN, NY 11211-7489
718-384-3475

**ODA PRIMARY HEALTH CARE CENTER**
517 PARK AVENUE
BROOKLYN, NY 11205-1631
718-260-4600

**Preventive Services**
The Fund’s Plan covers the following “preventive services” without a member co-payment provided you have a prescription from your physician:
- Aspirin to reduce risk of myocardial infarction for men and ischemic strokes for women;
- Folic acid supplements for pregnant women;
- Iron supplements for children ages 6 to 12 who are at risk for anemia; and
- FDA approved contraceptives (oral only).
IS A GENERIC SUBSTITUTION REQUIRED?

Yes. If a brand name medication has a generic substitution available the Fund will reimburse you for the cost of the generic medication only. You will be required to pay the difference between the generic cost and the brand name cost. **DIABETES MANAGEMENT COVERED BY BASIC CITY HEALTH PLANS**

Insulin, syringes, oral agents, diabetes testing and monitoring equipment, and supplies for controlling blood sugar are NOW covered under the basic program of **ALL** the health plans. The law also provides for diabetic management education to ensure that persons with diabetes are informed as to the proper self-management and treatment of their diabetic condition. It includes education relating to proper diet. Insulin and diabetic drugs covered by this program are no longer available through the Local 300 SEIU Welfare Fund’s Prescription Drug Benefits.

**WHO IS COVERED BY THE CITY’S PICA DRUG PROGRAM?**

All in-service members and **non-Medicare retirees** (under age 65) who have elected coverage by a City health plan. Members who have not elected a health plan (for example: Buyout Waiver Program) are **not** covered by this program and can continue to receive all covered prescriptions through their current prescription drug plan.

**WHICH DRUGS ARE COVERED BY THIS PROGRAM?**

The PICA program covers medication in two specific drug categories: **Injectable** and **Chemotherapy**. Some **examples** are:

- **Injectable** - most medications normally administered by injection (not in the doctor's office).
- **Chemotherapy** - medications used to treat cancer.

**HOW DO I GET INFORMATION ABOUT THE PICA PROGRAM?**

You can go to the New York City Office of Labor Relations’ website at [http://www.nyc.gov](http://www.nyc.gov) to obtain a detailed description of the PICA Drug Program.
Optical Benefits

WHO IS ELIGIBLE?

Covered members and eligible dependents.

WHAT DOES THIS BENEFIT PROVIDE?

This benefit is designed to provide prescription eyeglasses and contact lenses to all eligible participants who require them.

WHAT IS COVERED?

Each covered member and eligible dependents will be reimbursed for optical benefits per calendar year to a maximum of $200.00.

The member’s eligible dependents are entitled to one eye exam and one pair of prescription glasses each per calendar year.

ARE THERE PARTICIPATING OPTICAL PROVIDERS?

Yes, the Trustees of the Fund have made special arrangements with several providers of service so that a member may obtain these services at no out-of-pocket expense according to the plan provisions.

HOW DO YOU USE THE OPTICAL BENEFIT?

In order to use the optical benefit you must obtain an OPTICAL BENEFIT VOUCHER from the Fund’s TPA, Daniel H. Cook Associates, Inc., at (212) 505-5050 or the voucher can be downloaded from our Web Site (local300csf.org). A list of provider are on the web-site that have been approved by the Trustees and will give substantial discounts to Local 300 members.

YOU MAY GO TO ANY OF THE PROVIDERS AT ANY OF THE LOCATIONS AND THE AMOUNT OF PAYMENT BY THE FUND IS THE SAME.

Upon receipt of the OPTICAL BENEFIT VOUCHER, you should sign where indicated, as the voucher is not transferable. You will be asked to sign the voucher again at the time services are rendered.

DO YOU HAVE TO USE A PARTICIPATING PROVIDER?

No, you may go to any legally qualified optical provider. You will be reimbursed up to $200.00 for the exam and eyeglasses.
Podiatry Benefit

WHO IS ELIGIBLE?
All covered members and their eligible spouses.

WHAT DOES THE BENEFIT PROVIDE?
The maximum benefit is $200 per eligible person per calendar year. This includes expenses incurred for office visits, x-rays or physical therapy. This benefit does not apply to any other service or to services fully paid for by any other health plan.

HOW DO YOU OBTAIN THE BENEFIT?
Attach a receipt from the doctor to the Podiatry Benefit claim form. The statement must include the following:

1. an itemization of the services and fees charged.
2. the patient's name.
3. date of service.
4. diagnosis.
5. doctor's signature.

Submit the claim to the following address within 90 days of the date of service or it will be denied:

Local 300 SEIU Welfare Fund 253 West 35th Street 12th Floor New York, NY 10001

IF YOU OR YOUR SPOUSE'S HEALTH INSURANCE PAYS BENEFITS FOR PODIATRY CARE, YOU MUST FIRST SUBMIT YOUR CLAIM TO THAT CARRIER, AND ATTACH THEIR EXPLANATION OF BENEFITS TO THE LOCAL 300 SEIU PODIATRY BENEFIT CLAIM FORM.

Hearing Aid Benefit

WHO IS ELIGIBLE?
Covered members and their eligible dependents.

WHAT DOES THIS BENEFIT COVER?
The Fund offers a self-insured hearing aid benefit to all eligible members and their dependents who need a hearing aid. There is a maximum of $500 per ear for hearing aid purchase once every three years.

WHAT IS NOT COVERED UNDER THIS BENEFIT?
The purchase of batteries, repair of the device, or any other hearing aid service is not covered.

If hearing aid benefits are available through your basic health plan, you must submit the claim there first. The same rules and regulations governing the basic health plan's hearing aid benefits program apply regarding maximum reimbursement.

WHAT IS THE VOUCHER PLAN FOR HEARING AIDS?

At participating providers you are entitled to a paid-in-full benefit for a hearing aid evaluation, battery and one-year guarantee and unlimited visits and servicing in the first year. The device available at no cost to you is either a behind-the-ear or in-the-ear hearing aid (Electone, Otosonic or any comparable manufacturer's hearing aid).

This benefit is available once, per ear, every 24 months.

HOW DO YOU APPLY FOR THIS BENEFIT?

Call the Fund's TPA, Daniel H. Cook Associates, Inc. at (212) 505-5050 for a hearing aid benefit claim form.

Death Benefit

Member's Death

WHO IS COVERED UNDER THIS BENEFIT?

The Fund provides a benefit payable in the event of the death of the Covered Member while he/she is an eligible active employee as defined in the eligibility section of this booklet.

HOW DOES THE BENEFIT WORK?

In the event of your death while you are a covered member of the Fund the benefit will be paid to your designated beneficiary.

HOW MUCH IS THE BENEFIT?

The Death Benefit is $20,000 for active members up to age 62 at which point the benefit is reduced to $5,000.
WHAT IS EXCLUDED?

Any death resulting from the following events will not be covered:

- suicide;
- self-inflicted injury, while sane or insane;
- participation in or in consequence of having participated in the committing of a felony; or
- drug abuse.

HOW DO YOU DESIGNATE A BENEFICIARY?

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out and signing a beneficiary card provided by the Fund Office.

Spouse’s Death

WHO IS ELIGIBLE?

Active members only.

WHAT IS THIS BENEFIT?

The Fund provides a benefit to covered members upon the death of his/her spouse for the amount of $500.

HOW DO YOU APPLY FOR THIS BENEFIT?

You must notify the Fund Office upon the death of your spouse and provide an original death certificate to them.

Weekly Disability Benefit

WHO IS ELIGIBLE?

Active members that have been employed by the City, Authority or Higher Education for at least two years may receive this benefit.

WHAT ARE WEEKLY DISABILITY BENEFITS?

This is a benefit which pays you a weekly benefit for a disability if, while you are a covered member, you become totally disabled and unable to work because of a NON-OCUPATIONAL accident or illness.
WHAT REQUIREMENTS MUST BE MET IN ORDER TO RECEIVE THIS BENEFIT?

You do not have to be confined to your home to collect this benefit, but you **MUST** be under the care of a legally qualified physician. The member must be on approved sick leave or approved maternity leave from the City of New York or other qualified employer. Benefits are payable after the exhaustion of paid leave (annual and sick) or after the seventh day of disability, if the member receives less than seven days of paid leave.

The 18-week period is the maximum number of disability benefit weeks regardless of the number of disabilities claimed by a member during the disability period.

A disability will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

- the cause of the latest disability cannot be connected with the cause of any prior disability and the latest disability occurs after return to active work on a full time basis for at least one day, or

- a connection with prior disability can be established between the previous disability and the latest one but, in the period between both disabilities, you have returned to active work on a full time basis for at least two consecutive weeks.

- Submit proof of claim form to the Fund. Forms are available at the Fund Office where they may be picked up. Please call if you would like one mailed to you

HOW MUCH WILL YOU RECEIVE UNDER THIS BENEFIT?

This benefit is payable at the rate of $100 per week for a maximum period of 18 weeks during any two year (24 month) period.

YOU SHOULD REPORT WEEKLY DISABILITY CLAIMS PROMPTLY TO YOUR EMPLOYER AND THE WELFARE FUND OFFICE. DO NOT WAIT UNTIL YOU RETURN TO WORK TO MAKE YOUR CLAIM.
"(The assistance of counsel) is one of the safeguards of the Sixth Amendment deemed necessary to ensure fundamental human rights of life and liberty.... The Sixth Amendment stands as a constant admonition that if the constitutional safeguards it provides be lost, justice will not still be done."

United States Supreme Court Justice Hugo Black Gideon v. Wainwright
WHO IS ELIGIBLE?

If you are eligible for Local 300 S.E.I.U. Civil Service Forum Employees Welfare Fund benefits, you are eligible for legal services benefits described herein.

Your dependents are not eligible for legal services benefits unless specifically included in the benefit description.

GENERAL RULES REGARDING COVERAGE

Enrollment

To receive benefits, you must have completed a Local 300 S.E.I.U. Civil Service Forum Employees Welfare Fund ("Fund") Enrollment Card. The Enrollment Card provides the Fund with necessary basic information: your name, address, Social Security number, birth date, marital status, etc. If you have not completed an Enrollment Card, it is essential that you do so at the earliest possible opportunity.

All correspondence addressed to the Fund must contain the member’s name and address. Please notify the Fund Office, in writing, of any changes of name, address, etc. Maintenance of current records assures efficient processing of your claim and prompt receipt of your benefits.

Appeals to the Board of Trustees

The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions in this booklet are subject to such rules and regulations and to the Agreement and Declaration of Trust, which established the Fund and governs its actions.

A covered member may request a review of action taken by the Fund Office by submitting an appeal, in writing, to the Board of Trustees of Local 300 S.E.I.U. Civil Service Forum Employees Welfare Fund, attention: James Golden, Chairperson, 36-36 33rd Street Suite 200 Long Island City, New York 11106

HOW TO USE THE LEGAL SERVICES PROGRAM

If you wish to make an appointment to consult a lawyer for benefits provided, call the Fund Office or the panel law firm directly at (718) 895-7160. Identify yourself as a Local 300 member.

You will be provided with an attorney from the panel law firm selected by the Fund. This firm will provide the covered member with the benefits of the Benefit Trust Fund. Your relationship with this law firm will be that of attorney and client. The attorney-client relationship will be exclusively between the covered member and the law firm. No member of the Fund, or any Trustee of the Fund, can interfere in this relationship.
The Fund is designed to help pay for covered legal services. While the Fund cannot pay for all legal costs incurred, it will help meet a substantial amount of such costs. You should explore, with an attorney of the panel law firm, the cost involved for any problem for which you seek help so that you and the law firm will have a working concept of what services are covered as well as what you will have to pay yourself. Remember, however, that it is not always possible to estimate total costs. When, after general consultation with the panel law firm, you decide to retain the panel law firm, you will then be requested to make initial appropriate payment as indicated in the plan of benefits.

You are not compelled to use the plan provided by the Fund. You are free at all times to select an attorney of your own choosing and make payment to such an attorney for services. However, the Fund will not absorb or be responsible for any part of the fees or charges of attorneys other than those representing law firms on the panel for the legal services program.

You are also free at any time to discontinue the services of the panel law firm and if you desire, to secure the services of a non-panel attorney. However, in such an event, the Fund will neither be responsible for nor absorb any part of the fees or charges of such other attorneys. In addition, the covered member continues to be obliged to the panel law firm for any cost already incurred above the scheduled amount.

The panel law firm may, under exceptional circumstances, at any time (as is customary in the case of the independent retention of private attorneys) not undertake, discontinue or withdraw from representation of any covered member with appropriate adjustment of fees. In such cases, the covered member is free to secure his/her own counsel. However, the Fund will neither absorb nor be responsible for any of the fees or charges of a non-panel attorney.

You do not have to pay any subscription or registration fee to obtain the benefits of the Fund.

In instances where two covered members are involved in the same controversy or proceeding as adversaries, (and both members would have the right to the benefit under the rules of the Fund) each member will be provided access to an attorney or provided with a stipend by the Fund, at the discretion of the Trustees.

**REPRESENTATION IN CIVIL MATTERS**

The legal services benefits are divided into two major benefit categories: **Representation in Civil Matters** and **General Legal Matters**. All covered members are entitled to representation in no more than one (1) Civil Matter, each calendar year. Should you require representation is additional Civil Matters in a calendar year, you may submit written request for consideration to the Fund’s Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision in writing within a reasonable period of time. The following section concerns itself with the specific benefits within this category.
**Legal Defense Benefit**

**Who is Eligible?**

Any covered member who is a defendant in a situation involving his/her rights in resisting a claim and has had a legal action started against him/her which does not fall within any of the specified benefits listed in this booklet.*

**What is the Benefit?**

The Fund provides coverage through the panel law firm for all necessary legal services arising from the defense of a lawsuit or proceeding commenced against a covered member in courts and administrative agencies. The following are only examples of some of the courts and agencies in which the Fund provides coverage under the Legal Defense Benefit:

- Supreme, Surrogate's & District Courts of Westchester County
- United States District Court for the Eastern and Southern Districts of New York
- United States Customs Court
- Supreme, Surrogate's and County Courts of New York, Brooklyn, Queens, Richmond, Bronx, Nassau, Rockland, Putnam, Dutchess and Suffolk Counties
- Civil Courts of New York, Brooklyn, Queens, Richmond and Bronx Counties
- District Courts of Nassau and Suffolk Counties;
- Administrative Agencies and Bureaus.

Please note that special service benefits such as those involving divorce proceedings, separation proceedings, annulment proceedings, adoption proceedings, and homeowner proceedings are covered by the schedules and contained under those specific headings in this booklet.

This benefit provides, for example, the legal defense cost of a lawsuit alleging breach of contract or against lawsuits involving garnishment or medical expense claims. A covered member's problem may be successfully resolved after consultation with a panel attorney or it may necessitate the steps leading to and including your defense in a litigation or before an administrative agency.

As previously indicated, you are entitled to representation in no more than one legal defense matter every calendar year. Should you require representation in additional legal defense matters in a calendar year, you may submit a written request for consideration to the Fund's Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision within a reasonable period of time.
If a covered member is sued jointly with another defendant, including a spouse, the matter will not be covered by the Fund unless special circumstances are presented to the Trustees and approved. You may submit a written request for consideration to the Fund's Board of Trustees outlining your special circumstances to which the Trustees will render a written decision within a reasonable period of time.

The following schedule indicates the legal services available and the amount to be paid by you at each stage:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consultation</td>
<td>Nothing</td>
</tr>
<tr>
<td>B. Pre-litigation: including, for example, negotiation of settlement including the drafting of any necessary papers</td>
<td>$15</td>
</tr>
<tr>
<td>C. Litigation: including, for example, third party complaint, demand for Bill of Particulars, preparation of Jury Demand and Court Appearance, if necessary</td>
<td>$35</td>
</tr>
</tbody>
</table>

If the Legal Defense Benefit is concluded at the consultation stage there is no cost to the member. However, if the Legal Defense Benefit is concluded at the pre-litigation stage, the cost to you is $15; if the Legal Defense Benefit must enter the litigation stage, the cost to you is an additional $35. Hence, the total cost to the member for a Legal Defense Benefit that reaches litigation is $50 ($15 + $35).

**How is the Legal Defense Benefit Obtained?**

To obtain this benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

The acceptance of representation in all cases will be conditioned upon a determination by the panel law firm that the defense of the case is not frivolous. Such a determination will be made by the panel law firm and reported to the Trustees for a final determination.

**Exclusions**

- The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which involves a member’s or their spouse’s business, commercial or investment interest.
The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which results from actions taken by a member or the member's spouse acting on his/her own behalf as a general contractor for the construction of a new home or renovation of an existing home.

**Uncontested Legal Separation Benefit**

**Who is Eligible?**

Any covered member who seeks a separation from his/her spouse by means of a separation agreement mutually agreed upon by the parties or any relief through the court by an action for an uncontested legal separation.

**What is the Benefit?**

The Fund provides coverage through a panel law firm for all necessary legal services, which the preparation and negotiation of a separation agreement may require. The separation agreement may be prepared and executed with a minimum of consultation or it may necessitate extensive negotiation with opposing counsel and spouse.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

**Uncontested Divorce Proceeding Benefit**

**Who is Eligible?**

Any covered member is entitled to this benefit.

**What is the Benefit?**

Divorce proceedings may be categorized as Uncontested or contested. The Fund provides coverage for all steps of the legal process in the category of uncontested divorce proceedings.

The following schedule indicates the legal services available and the amount to be paid by you:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by the Fund through the Panel Law Firm</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncontested Divorce - Coverage includes, for example, the issuance of Summons and Complaint, Note of Issue, preparation of Findings of Fact, Conclusion of Law, Judgment and Entry of Judgment</td>
<td>$60</td>
</tr>
</tbody>
</table>
How to Obtain the Benefit

To obtain the Uncontested Divorce Proceeding Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Uncontested Annulment Proceeding Benefit

Who is Eligible?

Any covered member is entitled to this benefit.

What is the Benefit?

Annulment proceedings may be categorized as uncontested or contested. The Fund provides coverage for all steps of the legal process in uncontested annulment proceedings.

The following schedule indicates the legal services available and amount to be paid by the member in each circumstance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncontested Annulment - Coverage includes, Summons, Complaint, Note of Issue, Trial or Hearing, preparation of Findings of Fact, Conclusions of Law, Entry of Judgment and Finalization</td>
<td>$60</td>
</tr>
</tbody>
</table>

How to Obtain the Benefit

To obtain the Uncontested Annulment Proceeding Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Adoption Benefit

Who is Eligible?

Any covered member who seeks representation in an adoption proceeding is covered by this benefit.
What is the Benefit?

The Fund will provide you with an attorney from a panel law firm to represent you in formal adoption proceedings. This benefit does not include payment of any fees or expenses to adoption agencies or any other agencies, but is limited to those services normally rendered by an attorney to formalize an adoption. After all arrangements have been agreed upon, the panel attorney will prepare all petitions and allied papers and will appear in court with the parties in support of the adoption, if required.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Nothing</td>
</tr>
<tr>
<td>Preparation of Documents and Court Appearance for adoption of child</td>
<td>$65</td>
</tr>
</tbody>
</table>

How is the Adoption Benefit Obtained?

To obtain the Adoption Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Personal Bankruptcy Benefit

Who is Covered?

You are eligible if you are a covered member.

What is the Benefit?

The Fund provides coverage through the panel law firm for all necessary conferences and legal services in the preparation of a petition to file for personal bankruptcy. Such a petition and schedules to file for personal bankruptcy may be finalized with a minimum of consultation and negotiation or it may involve a number of exceedingly complex steps. In some situations, it may require attendance at meetings with creditors and settlement agreements.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Nothing</td>
</tr>
<tr>
<td>Preparation of Documents and Court Appearance for personal bankruptcy</td>
<td>$65</td>
</tr>
</tbody>
</table>
Consultation $0
Simple Personal Bankruptcy $75
Complex Personal Bankruptcy $100

How is the Personal Bankruptcy Benefit Obtained?
To obtain the Personal Bankruptcy Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Change of Name Benefits
Who is Covered?
You are eligible if you are a covered member.

What is the Benefit?
This benefit provides legal advice and representation in the change of name procedure. Counsel will file all appropriate papers and represent you in the change of name process.

The following schedule indicates the legal services available and the amount to be paid by you at each stage:

| Steps in the Legal Process Provided by the Fund through the Panel Law Firm | Amount
|---|---|
| Consultation | $0
| Actual change of name procedure | $45

How is the Change of Name Benefit Obtained?
To obtain the Change of Name Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Homeowner Rights Benefit
Who is Covered?
You are eligible if you are a covered member who owns a private dwelling, a condominium or cooperative apartment as a primary residence or is in the process of purchasing or selling such a primary residence or refinancing of a mortgage on a primary residence.
What is the Benefit?

This benefit has two components:

- Legal advice or representation for the sale or purchase of any private dwelling, condominium or cooperative apartment in which the member primarily resides or plans to reside; or the purchase of any unimproved property with the intention of building a home in which the member expects to primarily reside; or the refinancing of a mortgage on his or her primary residence. The legal services plan does not provide representation in any phase of the construction of a home; including closing on a construction loan, or in any controversy, dispute, proceeding or matter arising from the construction of any home, including one on which the member expects to primarily reside, unless special circumstances are presented to the Trustees in writing and approved.

- Legal advice or representation in the defense of a mortgage foreclosure proceeding involving any of the above stated residences.

Regarding the first component of this benefit, the following schedule indicates the legal services available and the amount to be paid by you in each instance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount Paid by You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>$0</td>
</tr>
<tr>
<td>Negotiation, Advice and Representation in the sale, purchase, or refinancing of a primary residence</td>
<td>$60</td>
</tr>
</tbody>
</table>

It should be noted that this benefit does not include any aspects of residential problems that involve Title searches or Title insurance nor the costs of same.

The second component of the Homeowner Rights Benefit is legal representation through the panel law firm attorney in defense of a proceeding to Foreclose a mortgage on a dwelling, which you own and in which you reside. A mortgage foreclosure problem may be resolved after consultation with a panel attorney or it may require the contesting of any action to Foreclose the mortgage in the appropriate court.
Steps in the Legal Process Provided by the Fund through the Panel Law Firm

<table>
<thead>
<tr>
<th>Steps in the Legal Process</th>
<th>Amount Paid by You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>$0</td>
</tr>
<tr>
<td>Pre-litigation: including for example, negotiation of settlement as well as the drafting of any necessary papers</td>
<td>$15</td>
</tr>
<tr>
<td>Litigation: including, for example, demand for Bill of Particulars, preparation of Jury Demand, Motions and Court Appearances</td>
<td>$125</td>
</tr>
</tbody>
</table>

How is the Homeowner Rights Benefit Obtained?

To obtain the Homeowner Rights Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

GENERAL LEGAL MATTERS

As indicated before, the legal services benefits of the Benefit Trust Fund are divided into two categories: Representation in Civil Matters and General Legal Matters.

This section describes the General Legal Matters of the Fund. These benefits are provided to you in those instances where your legal problems do not fall within the benefits provided within the Representation in Civil Matters category.

The following section describes the benefits included within the General Legal Matters category.

*General Consultation Benefit (three each year)*

Who is Covered?

All covered members are entitled to this benefit.

What is the Benefit?

This benefit provides you with an opportunity to consult with an attorney from the panel law firm for three one-half hour sessions each calendar year concerning any legal questions whatsoever. This benefit is made available by the Fund at no charge to you.
The General Consultation Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, any further legal costs must be borne directly by you.

How is the General Consultation Benefit Obtained?
To obtain the General Consultation Benefit, simply contact the Fund to request a consultation appointment. At the time of the consultation, you and an attorney from the panel law firm will complete the appropriate forms.

**Document Review Benefit**

Who is Eligible?
All covered members are entitled to this benefit.

What is the Benefit?
This benefit provides professional review and interpretation of all legal documents, such as: guarantees, warranties, installment purchase agreements, loans, leases, insurance policies and court papers previously prepared by an attorney from the panel law firm. There is no limitation placed upon the utilization of this benefit, which is provided at no cost to you.

The Document Review Benefit provides review and interpretation of documents only. The Document Review Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, then any further legal costs must be borne directly by you.

Exclusions and Limitations:
The following documents are not included in the Document Review Benefit:

- Tax Returns
- Work that is being prepared by other attorneys at the time of the Document Review Benefit.

How is the Document Review Benefit Obtained?
To obtain the Document Review Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.
Will Benefit

Who is Eligible?

Any member and/or his/her spouse/domestic partner who wishes to execute a Will or have one reviewed or updated is covered by this benefit.

In addition, the parent(s) or parent(s)-in-law of a member who wishes to execute a Will, or have one reviewed or updated, is covered by this benefit.

What is the Benefit?

This benefit provides for the preparation and execution of a simple will for you (if agreeable to the member), your parent(s) or your parent(s)-in-law under the supervision of an attorney from the panel law firm. This benefit is provided without charge not more than once in a 12-month period.

The Fund makes this benefit available at no charge to the member, his/her spouse/domestic partner, parent(s) or parent(s)-in-law.

How is the Will Benefit Obtained?

To obtain the Will Benefit, simply contact the Fund to request an appointment. If both member and spouse/domestic, mother and father, or mother- and father-in-law, desire a will, it is recommended that they make the appointment together. At the time of the appointment, the appropriate forms will be completed with the assistance of an attorney from the panel law firm. A second appointment will be necessary for the execution (signing) of the completed will(s).

Living Will/Health Care Proxy/Power of Attorney Benefit

Who is Covered?

You are eligible if you are a covered member, a covered member’s spouse/domestic partner, a covered member’s parent(s) and/or a covered member’s parent(s)-in-law.

What is the Benefit?

This benefit provides you, your spouse/domestic partner, your parent(s) and/or your parent(s)-in-law with the opportunity to have a living will, health care proxy and/or power of attorney prepared and executed under the supervision of an attorney from the panel law firm. This benefit is provided once every two calendar years at no cost.
A living will and/or health care proxy serves as a clear documented expression of an individual's carefully considered intention to have life-sustaining procedures withheld or withdrawn if he or she were to suffer from a catastrophic illness, disease or injury from which there is little likelihood that he or she would recover to enjoy a meaningful quality of life.

A power of attorney appoints an individual of your choosing to conduct your affairs immediately or upon the happening of a catastrophic event, which results in your incapacity.

**How is the Living Will/Health Care Proxy/Power of Attorney Benefit Obtained?**

To obtain the Living Will/Health Care Proxy Benefit, either you or your spouse/domestic partner should contact the Fund to request an appointment. If both husband and wife desire a living will, health care proxy and/or power of attorney, it is recommended that you make an appointment together. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**Appointment of Agent To Control Disposition of Remains Benefit**

**Who is eligible?**

Any covered member, covered member’s spouse/domestic partner, covered member’s parent(s) and/or parent(s)-in-law.

**What is the benefit?**

This benefit provides you, your spouse/domestic partner, your parent(s), and/or parent(s)-in-law with the opportunity to have an Appointment of Agent to Control Disposition of Remains document prepared and executed under the supervision of an attorney from the panel law firm.

An Appointment of Agent to Control Disposition of Remains serves as a clear documented designation of a burial agent and expression of special directions of how the individual’s burial is to be accomplished.

The Fund makes this benefit available at no charge to member.

**How is the benefit Obtained?**

To obtain the Appointment of Agent to Control Disposition of Remains benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.
**Designation of Person in Parental Relation Benefit**

**Who is Eligible?**

You are eligible if you are a covered member.

**What is the Benefit?**

This benefit provides the covered member with the opportunity to have a Designation of Person in Parental Relation ("Designation") prepared and executed under the supervision of an attorney from the panel law firm.

A Designation designates another person (the “Designee”) as a person in parental relation to a minor or incapacitated person to act on his/her/their behalf in matters relating to education and health care. The Designation is a very useful document for parents who must leave their child with a caregiver for a limited period of time. If drafted properly, the Designation will be valid for up to 6 months.

**NOTE:** With respect to a covered member who wishes to be named Designee, an attorney from the panel law firm will provide a special consultation to confirm that a Designation one may receive is in conformity with the law.

**How to Obtain the Benefit?**

To obtain the Designation of Person in Parental Relation Benefit, you should contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**Planning for the Elderly Benefit**

**Who is Covered?**

You are eligible if you are a covered member, a covered member's spouse/domestic partner, a covered member's parent(s), or a covered member's parent(s)-in-law.

**What is the Benefit?**

This benefit provides you, your spouse/domestic partner, your parent(s), and/or your parent(s)-in-law with an opportunity to consult with an attorney from the panel law firm on matters involving the placement of elderly in nursing homes, available Medicare entitlements and health planning for the elderly. This benefit includes the preparation of powers of attorney and is offered at no cost to you.
How is the Planning for the Elderly Benefit Obtained?

To obtain the Planning for the Elderly Benefit, either you or your spouse should contact the Fund to request an appointment. At the time of the appointment, an attorney from the panel law firm will complete the appropriate forms with the client.

Probate and Estate Administration Benefit

Who is Covered?

Any member; member's eligible dependent who is named Executor in a Will; an Executor named in a Will by a covered member and/or if there is no Will, a member or an eligible dependent who would qualify under intestacy laws to serve as Administrator of the estate is covered by this benefit.

What is the Benefit?

The Fund provides all legal services, which may be required in connection with the handling of an estate from its inception (the probate of a Will or Petition for Letters of Administration where there is no Will), through all phases of estate administration including tax proceedings and "winding up" of the estate (through accounts and distribution).*

With respect to the estate of a deceased member, these services are provided to the surviving spouse or eligible dependent children in those instances where the spouse or eligible dependent children would be entitled to be appointed Executor or Administrator.

PLEASE NOTE: This benefit DOES NOT provide legal services of an adversarial nature, e.g., to contest an existing Will.

The panel law firm has agreed to provide legal representation in these matters with a 25% reduction in its hourly rate, which for 2015 is $350 (less 25% equals $262 per hour). There is no charge for a consultation.

How is the Probate and Estate Administration Benefit Obtained?

To obtain the Probate and Estate Administration Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

Arraignment Assistance - Telephone Consultation Benefit

Who is Eligible?

You are eligible if you are a covered member or dependent who is a defendant in a criminal proceeding in Nassau, Suffolk, Westchester, Putnam, Dutchess or Rockland Counties, or the boroughs of New York City.
What Is the Benefit?

This benefit provides coverage through the panel law firm for legal assistance arising from an arrest, which may lead to immediate imprisonment.

This benefit provides, for example, telephone consultation by an attorney where you or your dependent are charged as the defendant in a criminal matter. It is important to note, however, that this benefit does not cover the costs of legal assistance beyond this stage. If you or your dependent are interested in obtaining legal services beyond the arraignment stage, you must make the necessary arrangements directly with the panel law firm or retain another attorney of your choice.

The following schedule indicates the legal services available and the amount to be paid by you at each stage:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>The Fund through the Panel Law Firm</td>
<td>Consultation</td>
<td>$0</td>
</tr>
</tbody>
</table>

Consumer Protection Benefit

Who is Covered?

Any covered member is entitled to this benefit.

What is the Benefit?

This benefit provides you with coverage through the panel law firm for a broad range of legal services which might be needed to institute and pursue action against fraudulent practices by merchants, department stores, home repair contractors, public utilities, automobile dealers, appliance dealers, etc. Utilization of this benefit is limited to two matters per member per calendar year and the matter must involve a purchase costing $500 or more.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance: Steps in the Legal Process Provided by

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</tr>
<tr>
<td></td>
<td>Representation by Written Communication</td>
</tr>
<tr>
<td></td>
<td>Litigation in Small Claims Court</td>
</tr>
<tr>
<td></td>
<td>Litigation in Courts other than Small Claims Court</td>
</tr>
<tr>
<td></td>
<td>Small Claims Court</td>
</tr>
<tr>
<td></td>
<td>Representation with Appropriate Federal Agencies (e.g. F.T.C., etc.)</td>
</tr>
</tbody>
</table>
* If a lawsuit involves a consumer purchase of $5,000 or more e.g., “lemon” car -then the cost to you for litigation or representation will be $250.

Some legal services that are not provided under this benefit include, but are not limited to, suits for punitive damages, class actions and commercial enterprises.

**How is the Consumer Protection Benefit Obtained?**

To obtain the Consumer Protection Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**Identity Theft Protection Benefit**

**Who is eligible?**

Any member who wishes legal consultation in connection with an identity or personal information theft issue is covered by this benefit.

**What is the benefit?**

The Fund provides coverage through the panel law firm for a member to consult with an attorney if the member believes he/she has been the victim of an act of identity or personal information theft including but not limited to the following examples:

- using or opening of a credit card account in the member’s name, fraudulently;
- opening telecommunications or utility accounts in the member’s name, fraudulently;
- passing bad checks or opening a new bank account in the member’s name, without authorization; and
- obtaining a loan in the member’s name, fraudulently.

The panel law firm will provide consultation and assistance* to a member in connection with their contacting and reporting an act of identity theft to the three major credit bureaus, the security departments of the appropriate creditors or financial institutions, the police and the Federal Trade Commission.

The Fund makes this benefit available at no charge to member.

**How is the Identity Theft Benefit Obtained?**

To obtain the Identity Theft Benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

*The Identity Theft Benefit does not include representation in litigation other than that already provided in the Consumer Protection Benefit.
GENERAL EXCLUSIONS FROM ALL LEGAL SERVICES BENEFIT OF THE FUND

All legal services provided by the Fund have been specifically stated and described. Any legal service that has not been so described can be considered excluded from the Fund’s legal services plan of benefits.

However, to guide you in your use of the Fund's legal services benefit package, this section lists specifically, but without limitation, particular exclusions from the Plan:

- Any controversy, dispute or proceeding with or against the employer or the employer's agents or officers;
- Any controversy, dispute or proceeding directed against the Union or any of its affiliated bodies, e.g., the Trust Fund, or any of the officers, agents or attorneys of the Union and its affiliated bodies;
- Any controversy, dispute or proceeding in which the Fund would be prohibited from defraying the cost of legal services by any provisions of the law;
- Any controversy, action or proceedings in which representation on a contingent fee basis is normally and customarily available or where the fee is payable by virtue of statute or by order of court;
- Class actions or interventions or amicus curiae activities. Two or more parties may not pool or combine their benefits for the purpose of asserting a claim in which they have a mutual interest;
- Any matter concerning the preparation or filing of income tax returns or payment of income taxes;
- Any controversy, action, proceeding or dispute in which the legal services are available through insurance or through any government agency or attorney (Federal, State or local);
- Any controversy, dispute or proceeding in which you hired a lawyer before you became eligible to receive benefits under the Plan;
- Any legal expenses incurred for a matter which commenced before you became eligible to receive a benefit under the Plan;
- Any controversy, dispute, proceeding or matter that cannot be litigated or otherwise handled within Nassau, Suffolk, Westchester, Putnam, Rockland and Dutchess Counties, or the five boroughs of New York City as described in the Legal Defense Benefit section;
- Any controversy, dispute, proceeding or matter which involves a member’s business, commercial or investment interest;
The Fund will not pay claims for services or advice when such activity involves a duplication of the same service or advice previously obtained in connection with the same problem and previously claimed for under the Plan;

The Fund will not pay court costs and/or filing fees, nor in any event will the Fund pay fines, penalties or any amounts in which a member may be cast in judgment.

IF YOU HAVE ANY QUESTIONS ABOUT COVERAGE, BENEFITS OR EXCLUSIONS, PLEASE CONTACT THE FUND OFFICE, (718) 895-7160 or (516) 466-6030.