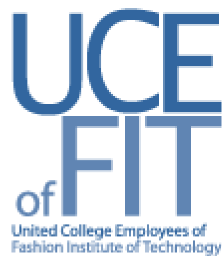
UNITED COLLEGE EMPLOYEES OF FASHION INSTITUTE OF TECHNOLOGY WELFARE TRUST FUND

BENEFIT BOOKLET

December 2023

FULL-TIME MEMBERS' BENEFITS



WELFARE TRUST FUND

United College Employees
Of
Fashion Institute of Technology
Welfare Trust Fund

TRUSTEES

Ellen Lynch, Chairperson
Paul Clement, Secretary
Linda Tain
Juliette Romano
Eric Ramirez
Roberta Elins
Isabella Bertoletti
Chenise Marine Rice
Felix Rivera Perez

ACTUARIAL AND BENEFITS CONSULTANT/THIRD PARTY ADMINISTRATOR

Seneca Consulting Group, Inc.

ACCOUNTANT

Weaver

COUNSEL

Mirkin & Gordon, P.C.

INVESTMENT MANAGER

Stacey Braun Associates, Inc.

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HIGHLIGHTS OF YOUR BENEFITS

(Please refer to the applicable sections of this booklet for a detailed description of the following benefits)

Prescription Drug Plan:

For prescriptions written by a licensed medical provider:

If prescriptions are filled by a participating retail pharmacy or through the Fund's mail order pharmacy, the following co-payments will apply:

Retail – up to a 30 day supply	Mail – up to a 90 day supply
$20.00 generic	$40.00 generic
$30.00 preferred brand	$60.00 preferred brand
$50.00 non-preferred brand	$100.00 non –preferred brand

- $50 Deductible per year per covered individual
- No annual or lifetime maximums;
- Mandatory generic requirement
- I.D. Card provided

Dental Benefits:

Maximum coverage of $3,000 per covered individual per calendar year based on the Fund's dental schedule.

Effective January 1, 2013, there is a $50 deductible per covered individual. The annual deductible is waived for diagnostic and preventive services.

Optical Reimbursement Benefits:

The Fund provides an optical benefit allowance of up to $100.00 on a rolling 12-month basis per covered eligible individual.

Hearing Aid Reimbursement Benefits:

The Fund provides a hearing aid benefit allowance (for both ears) of up to $500.00 on a rolling 5-year basis.

Accident and Sickness Benefits:

The Fund provides an Accident and Sickness benefit to covered members only who become disabled. The benefit is one-half of the member's day wage, to a maximum of $87.50 per day for a maximum period of 28 weeks.

Health Advocate Program:

The Fund provides a Health Advocate Program designed to help you and your families handle healthcare and insurance related issues by cutting through the red tape and barriers that so often create frustration and problems.

Legal Services Plan:

The Fund provides a comprehensive legal services plan, which stresses the "preventative medicine" approach to provide accessibility to counsel by all members.

GENERAL INFORMATION

WHO IS COVERED

Employees of the Fashion Institute of Technology (referred to hereafter as "the College") who are "covered" under the collective bargaining agreement between the United College Employees of Fashion Institute of Technology (referred to hereafter as the "UCE of FIT") and the College and for whom the College contributes monies to the United College Employees of Fashion Institute of Technology Welfare Trust Fund (referred to hereafter as "the Fund") on the employees' behalf are "covered employees". "Covered employees" are hereinafter referred to as "members."

In addition, Fund benefits are provided to other employees who may be deemed eligible by the Fund's Board of Trustees.

ELIGIBILITY

A. Members

In general, members in covered categories receive benefits as long as they maintain active full-time employment status. Active employment status is determined by, and is coextensive with, the period for which employer contributions are paid, or should have been paid for the member, by the College, to the Fund. Members on an authorized paid leave from employment are considered to be on active status. Eligibility terminates when members cease to have active full-time employment status.

B. Dependents

The dependents of eligible members as defined below are eligible for all Fund benefits except Accident and Sickness Disability Benefits.

Dependents are defined by the Fund as follows:

1. ***Spouse*** – The lawful wife or husband of the member.

2. Domestic Partners -

A member's domestic partner is defined by appropriate Executive Order of the City of New York (or where they reside)

You must provide an enrollment form and a Domestic Partner Certificate from the City to the Fund office to enroll your domestic partner for Fund coverage. A qualified Domestic Partner becomes eligible on the date the foregoing documents are submitted to the Fund office.

The Fund will also accept a Domestic Partner Certificate from a jurisdiction other than New York City that has a domestic partner registry.

If you do not live in a jurisdiction, which recognizes domestic partners, you may still enroll your domestic partner with the Fund, by obtaining

3. Children are defined as follows:

- ***Natural and Legally Adopted Children -*** A member's natural or legally adopted child (and while in the waiting period) who is under age 26;
- ***Stepchildren -*** A member's stepchild who is under age 26 may be eligible for benefits provided they permanently reside with and are chiefly dependent upon you, the member, for support and maintenance and are enrolled with the Fund, by you, when you enroll or when they initially become your dependents
- ***Other Children*** Any child who is under age 26 and permanently resides in the member's household and is chiefly dependent upon you, the member for support, for whom the member or member's spouse/domestic partner is the legal guardian. The Court Order appointing the legal guardian must be provided upon enrollment of the child.

When a covered child turns 26, his/her benefits through the Fund will end the last day of his/her birth month. (For example, if the child turns 26 on July 17, 2022 his/her last day of coverage will be July 31, 2022). An adult child is not eligible for Fund coverage if he/she is eligible for similar benefits through the plan of his/her own employer or his/her spouse's employer.

A child who is physically or mentally incapable of self-support, who permanently resides with you and is an eligible dependent under the Fund's benefits plan upon attaining age 26 may be continued under the Plan while remaining so incapacitated and unmarried, subject to your own coverage remaining in effect. To continue a child under this provision, proof of incapacity must be received by the Fund within 31 days after coverage would otherwise terminate (due to the child attaining the age of 26). Additional proof will be required periodically.

The eligibility of a dependent terminates when a member's eligibility terminates or when the dependent no longer meets the definition of eligible dependent, whichever occurs first.

No person may be eligible for benefits both as a member and as a dependent of a member, or as a dependent of more than one member. (See page 11).

How to Enroll

You must complete a Fund Enrollment Form. When you have a change of address, marital status, or dependent status, you must file a Change of Address, Marital Status, and Dependent Form, available from the Fund Office.

Upon divorce, legal separation or dissolution of a domestic partnership you must file a Change of Address, Marital Status, and Dependent Form your spouse or domestic partner. When enrolling dependents, you must attach to the Fund Enrollment Card or Change of Address, Marital Status, and Dependent Card photocopies of documentation verifying dependent status/legal guardianship. The Fund reserves the right to request documentation verifying the bona fide relationship of any dependent (e.g. a birth certificate or a marriage certificate).

MEMBER CONTRIBUTIONS

The benefits provided by the Fund were also achieved through collective bargaining. They are financed by contributions made to the Fund by the College as specified in the collective bargaining agreement. In addition, through automatic payroll deductions, Full time employees will pay $30 per paycheck for single coverage ($720 per year) and $40 per paycheck for family coverage ($960 per year).

When Does Coverage Begin

Your coverage for all benefits begins on the 31st day of your active, full-time status with the Fashion Institute of Technology.

Dependents become eligible on the same date as you, or if added later, on the date they first become eligible dependents and are duly enrolled.

IN ORDER FOR YOUR ELIGIBLE DEPENDENTS TO BE COVERED BY THE FUND, YOU MUST ALSO SUBMIT COPIES OF THE FOLLOWING APPLICABLE DOCUMENTS WITHIN THIRTY-ONE (31) DAYS OF THE EVENT OR YOUR DATE OF HIRE, WHERE POSSIBLE:

1. Marriage Certificate
2. Birth Certificate
3. Domestic Partner Registration Certificate
4. Legal Adoption papers
5. Legal Guardianship papers
6. Prior year’s Tax Returns
7. For physically or mentally disabled, dependent children under age 26: a letter from a physician stating the physical or mental incapacity, date of onset, and expected duration of disability.

How to Obtain Claim Forms

Dental, optical and hearing aid claim forms, may be obtained on the UCE-FIT.org website under the Welfare Trust Fund tab. Also, you can visit the Fund Office (B902) – telephone number: (212) 217-3370 or by calling the Fund's Third Party Administrator Seneca Consulting Group at (866) 487-4157**.**

NON-DUPLICATION OF BENEFITS

Under this rule a member cannot be covered both as an employee and as a dependent at the same time. Therefore, if your spouse or domestic partner also works for the College each must enroll separately:

Please note, only one of you may cover your dependent children. Member contributions must be remitted by both individuals.

AMENDMENT AND TERMINATION OF BENEFITS

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. 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 Agreement, which established the Fund and governs its operations.

Your coverage and your dependents' coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- When there is non-payment of the direct pay premiums.
- When the Employer ceases to make contributions on your behalf to the Fund.

Your dependents' coverage will also terminate when they are no longer eligible dependents.

Member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits. The Trustees may expand, modify or cancel the benefits for members and dependents; change eligibility requirements or the amount of the self-pay premiums; and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

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 (including Workers' Compensation cases). Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

(A) To reimburse the Fund, to the extent of benefits paid to it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise;

(B) To provide the Fund with an Assignment of Proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund in seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and

(C) 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 or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits payable to a deceased member upon the date of death, or with respect to death benefits payable by virtue of the death of the member where the member's designated beneficiary has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member's:

A. Surviving spouse/domestic partner;

B. If no surviving spouse/domestic partner, to the surviving children equally, or

C. If no surviving children, to the covered member's estate.

RIGHT TO APPEAL

The benefits provided by this Fund may be changed by the Board of Trustees in their sole and absolute 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 Agreement, which established and governs the Fund operations.

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject only to review by the Board of Trustees. A member or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees within sixty (60) days of the decision being denied:

United College Employees of Fashion Institute of Technology Welfare Trust Fund
Seventh Ave. at 27th Street Room B902 New York, New York 10001

The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE

The Fund has the right to recoup overpayments that were made as a result of an error in the processing of a claim, or, if additional information comes to the attention of the Fund after the claim has been paid. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayments or have in any way abused the Fund's benefit program.

If the Fund finds it has overpaid you, or on behalf of an otherwise ineligible dependent, for a particular benefit, it has the right to recoup the excess amount from you. The Fund may bill you for overpayments made, and/or, it may also reduce future benefit payments to offset the overpaid amounts or it may suspend your benefits until the overpayment is recouped.

COORDINATION OF BENEFITS

There is no coordination of benefits between members married to, or domestic partners with, another member, or their children.

In the event that a person covered by the United College Employees of Fashion Institute of Technology Welfare Trust Fund is covered under another group plan, there will be "coordination of benefits" regarding reimbursement by this Fund. This coordination will apply in the event that an expense is incurred for a covered item under this Fund that is also covered under the other plan. A determination will be made as to which plan is "primary", or the first plan to pay, and which plan is the "secondary" payer. The method to determine which plan is primary is based on the following rules:

1. If the claimant is a covered member of the Fund, then the Fund will pay benefits first, while a plan covering a member as a dependent will pay second.
2. If a dependent child is covered by plans of both parents, the benefits of the plan,

which covers the child of the parent whose date of birth (month and day only, excluding year) occurs earlier in the calendar year, will be determined to be the primary payer. The benefits of the plan which covers the child of the parent whose date of birth (excluding the year) occurs later in the calendar year, will be determined the secondary payer. If a plan containing this "Birthday Rule" is coordinated with a plan, which contains a gender-based rule, and, as a result the plans do not agree on the order of benefits payment, the gender-based rule plan will determine the order.

3. When parents are divorced or separated, the order of benefit payment for a dependent child is:

(a) The plan of the parent with custody pays first and the plan of the parent without custody pays second.

(b) If the parent with custody has remarried the order is:

 (1) The plan of the parent with custody pays first.

 (2) Next, the plan of the step-parent pays.

 (3) The plan of the parent without custody pays last.

If there is a court decree, which states that one parent is responsible for the child's health care expenses, the plan of that parent will pay first. That court decree will supersede any order stated above.

4. If a person is covered under more than one plan, the plan that he or she was under for the longer time period pays first, as if there were no other plan. If this Fund is the secondary plan, it will coordinate the benefits with the primary plan so that no greater than 100% of the allowable expense will be paid.

If you or your family members are eligible to receive benefits under another group plan in addition to this one, benefits will be coordinated with the benefits from your 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 include a copy of the payment voucher ("Explanation of Benefits" Form) from the primary plan when filing a claim with the secondary plan.

NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the United College Employees of Fashion Institute of Technology Welfare Trust Fund ("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 was previously distributed to all members and 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 the Fund's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

CONTINUATION OF COVERAGE

A. Statutory Continuation of Coverage

1. COBRA CONTINUATION OF COVERAGE

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

COBRA continuation coverage for the Fund is administered by the Fund Administrator, Seneca Consulting Group, Inc. tel. (1-866) 487-4157.

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is some one who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, domestic partners, and dependent children of employees may be qualified beneficiaries. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You or your dependents will be required to pay the necessary premium for the following benefits:

- Dental Benefit Plan
- Optical Benefit Plan
- Hearing Aid Benefit Plan
- Prescription Drug Benefit Plan

The following language is required by federal health care law. The Fund cannot represent whether or not dental, optical, hearing aid, standalone prescription drug benefits and other supplemental benefits are available through the Health Insurance Marketplace.

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.

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

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

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

1. Your spouse or domestic partner dies;
2. Your spouse's or domestic partner's hours of employment are reduced;
3. Your spouse's or domestic partner employment ends for any reason other than his or her gross misconduct;

   Your spouse becomes or domestic partner enrolled in Medicare

   (Part A, Part B, or both); or
4. You become divorced or legally separated from your spouse.

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

1. The parent/employee dies;
2. The parent/employee's hours of employment are reduced;
3. The parent/employee's employment ends for any reason other than his or her gross misconduct;
4. The parent/employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Fund as a "dependent child."

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Fashion Institute of Technology, and that bankruptcy results in the loss of coverage of any employee covered under the Fund, the employee is a qualified beneficiary with respect to the bankruptcy. The employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Fund

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund 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 employee, commencement of a proceeding in bankruptcy with respect to the employee, or enrollment in Medicare (Part A, Part B, or both), the employer must notify the Fund Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse, domestic partner or a dependent child's losing eligibility for coverage as a dependent child), YOU must notify the Fund Administrator. The Fund requires you to notify the Fund Administrator within 60 days after the qualifying event occurs. You must send this notice to the, Fund Administrator. In the event of death, a copy of the death certificate must be provided. In the event of enrollment in Medicare, you must send a copy of the Medicare card. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation.

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event or on the date that Fund coverage would otherwise have been lost, if later.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

a. Disability Extension of 18month Period of Continuation Coverage:

If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Fund Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Fund Administrator is notified of the Social Security Administrator's determination by sending a copy of the Determination letter within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Fund Administrator.

b. Second Qualifying Event Extension of 18-month Period Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Fund as a dependent child. **In all of these cases, you must make sure that the Fund Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Administrator.** In the event of death, a copy of the death certificate must be provided. In the event of enrollment in Medicare, you must send a copy of the Medicare card. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation.

Are there other coverage options besides COBRA Continuation Coverage?

The following language is required by federal health care law. The Fund cannot represent whether or not dental, optical, hearing aid, standalone prescription drug benefits and other supplemental benefits are available through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program or any other group health plan.

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

For more information visit https://www.medicare.gov/medicare-and-youIf You Have Any Questions

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

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund 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 Fund Administrator.

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

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible employees of the College with up to twelve (12) weeks of family leave in a twelve (12) month period to care for a dependent child, covered family members or for the serious illness of the employee. If you take a FMLA leave, the College must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation of coverage. Upon submission by the College to the Fund of documentation verifying your FMLA status, the Fund will provide benefits during the FMLA period. Since no paychecks are being issued during this period, continuation of Fund coverage is conditioned upon the member paying the annual contribution of ($780.00) ***single*** ($960.00) ***family*** directly to the Fund for the entire period of the authorized FMLA leave.

B. Non-Statutory Continuation of Coverage

1. CONTINUATION OF COVERAGE WHILE ON AN AUTHORIZED UNPAID LEAVE OF ABSENCE

The College will continue to provide health and welfare benefits to tenured, full-time employees for the duration of an authorized unpaid leave of absence. The Fund will also continue to provide benefits during an authorized unpaid leave of absence however, since no paychecks are being issued during this period, continuation of Fund coverage is conditioned upon the member paying the annual contribution of $720/$960 directly to the Fund for the entire period of the authorized unpaid leave.

2. EXTENSION OF COVERAGE FOR SURVIVING SPOUSE/DOMESTIC PARTNER AND CHILDREN UPON A MEMBER'S DEATH.

Upon the death of a covered member, the Fund will continue to cover his/her surviving spouse/domestic partner and eligible children for up to 12 months, Thereafter, a surviving spouse/domestic partner or child may elect COBRA continuation coverage and pay the applicable premium for same.

3. RETIREE COVERAGE

a. Retirees not in a Tier III or Tier IV Pension

You are eligible to be covered by the UCE of FIT Welfare Trust Fund benefits plan for retirees, if all of the following criteria are met:

1. You retired from employment from the Fashion Institute of Technology; and
2. You are eligible to receive a pension check from a retirement system and you have certified in writing that (1) you have applied to receive a benefit under an approved FIT employee retirement plan or (2) it has been determined by the retirement plan that you are entitled to receive such a benefit;
3. You were covered by the UCE of FIT Welfare Trust Fund immediately prior to your retirement; and
4. You are not currently employed by the Fashion Institute of Technology or any other employee in a position that entitles you to benefits under the UCE of FIT Welfare Trust Fund.

The Fund's Benefits Booklet for Retiree Members contains a complete description of the benefits plan for retirees

b. Retirees in a Tier III or Tier IV Pension

If you are a vested retiree in a Tier III or Tier IV Pension, you are not eligible to receive benefits from the UCE of FIT Welfare Trust Fund until you reach age 62. However, upon retirement, you may continue your active benefits through the Fund subject to your payment of a monthly self-pay contribution, equivalent to the monthly contribution paid by the Fashion Institute of Technology on behalf of each covered active member.

SOME GENERAL QUESTIONS AND ANSWERS

What is the Fund?

The Fund was established as a result of collective bargaining between the UCE of FIT and the College. Contributions are predicated on the amount stipulated in the current Collective Bargaining Agreement. Contributions are provided by the College at the annual rate, prorated monthly, on your behalf In addition, through automatic payroll deductions, members contribute. This rate is subject to change at any time ($780.00) ***single*** ($960.00) ***family*** by the Board of Trustees.

Who Administers the Fund?

The Fund is administered by a Board of Trustees. It consists of five persons designated by the UCE of FIT Executive Committee. The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Board of Trustees employs an Administrator and staff who are responsible for the day-to-day operation of the Fund, including the determination of eligibility and the processing of claims. Decisions of the Administrator and of the staff are subject to review and reconsideration by the Trustees upon appeal as described on page13 of this booklet.

Do the contributions to the Fund become part of the general treasury of the Union?

No. The UCE of FIT and the Fund are two distinct and separate legal entities. Their resources are not commingled.

HOW TO DECLINE DENTAL AND OPTICAL COVERAGE

Members may decline coverage of Welfare Fund dental and/or vision benefits for themselves and/or any enrolled dependents at any time by completing a Declination of Coverage form, which can be obtained by contacting the Fund office.

Members who decline coverage for dental and/or vision benefits will not receive a reduction or rebate of their member payroll deduction contributions or any other compensation from the Fund.

What becomes of the contributions that the College makes to the Fund?

Contributions to the Fund are used to provide benefits for the covered employees and to finance the cost of administration.

How do I obtain information and claim forms from the Fund?

Information and claim forms are available from the Fund Office, Room B902, telephone number: (212) 217-3370 or on our website www.uce-fit.org under the Welfare Trust Fund tab. Information can also be obtained by contacting the Fund Administrator, Seneca Consulting Group, Inc. at (1-866) 487-4157.

Does the Fund operate under ERISA?

No. The Fund is not subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”).

PRESCRIPTION DRUG PLAN

The Fund's prescription drug plan is administered by. ProAct, 1226 US Highway 11, Gouverneur, NY 13642-9926

Who is covered (Active, full-time members only)

You and your eligible, enrolled dependents, as defined in the "General Information" Section (page 8), become covered for prescription drug benefits on the 31st day after you have acquired active full-time status, provided you enroll your eligible dependents and provide the requisite information confirming their eligibility. ProAct will issue a plastic UCE of FIT/ESI I.D. Card, which lists your name. However, eligibility for benefits will be determined solely in accordance with the aforementioned "General Information" Section, even if your I.D. Card has not expired or if errors appear on the I.D. Card.

The reverse side of the UCE of FIT Welfare Trust Fund/ProAct I.D. Card states that the "Card is void when your eligibility terminates." This statement applies regardless of the expiration date printed on the front of the Card.

What are the Benefits

Benefits are available for drugs, which, by law, require a prescription written by a licensed practitioner. If your prescription is filled by a Participating Pharmacy in accordance with the required procedures as specified below, and you use a valid I.D. Card, you will pay the applicable co-payment and the pharmacy will be reimbursed for the allowable balance directly by ProAct. If these procedures are not followed, or if a non-Participating Pharmacy fills the prescription, you will be required to pay the pharmacy directly and then file a direct claim with ProAct. Reimbursement of the charges will be made in accordance with a specific schedule of allowances. In these instances, if the charge exceeds the amount allowed, you will incur an out-of-pocket expense in addition to the co-payment.

Your co-payments are as follows:

$50 deductible per year per covered individual
Retail – up to a 30-day supply
$20 generic
$30 preferred brand
$50 non-preferred brand

Mail – Up to a 90-day supply
$40 generic
$60 preferred brand
$100 non-preferred brand

Generic drug - is the chemical equivalent of a brand drug that has an expired patent. When a brand name drug's patent expires, multiple pharmaceutical companies can produce the same active chemical compound and sell the drug under its generic name.

A preferred brand drug - has superior safety, clinical efficacy or/and cost-effectiveness compared to other brand drugs in a therapy class.

A non-preferred brand drug - is similar to other preferred brand drugs in a therapy class but does not possess superior safety, clinical efficacy and/or cost-effectiveness to justify preferred status.

Specialty Drugs

All prescriptions for a Specialty Drug, including refills, will be subject to a 50% copayment. **This includes drugs for the treatment of HIV.**

You will be able to obtain copayment assistance through a program administered by Noble Health Services, ProAct's Specialty Drug Pharmacy. Your full cooperation is required in order to ensure maximum copayment assistance. If you are successful in obtaining copayment assistance, your copayment should not be more than $50 per prescription for a 30-day supply of your Specialty Drug. In some instances, it may be less. If you do not cooperate with Noble Health Services in the provision of information or completion of forms for the copayment assistance, then your copayment for your Specialty Drug will be 50% of the cost to the Fund of that drug. If you are taking a drug for which there is no copayment assistance available, or you do not qualify for assistance after providing all required documentation, your copayment will be $50.

A list of the Specialty Drugs for which copayment assistance is currently offered by manufacturers is available on the Fund's website at UCEofFIT.org/Welfare Fund tab. For all questions concerning the copay assistance program, please call ProAct at 1-877-635-9545.

All prescriptions for Specialty Drugs, including the first fill and all refills thereafter, must be filled through ProAct's Specialty Pharmacy, Noble Health Services, via mail.

$0 Copayment for Preventive Medications and Birth Control

The Federal Affordable Care Act (ACA), requires "non-grandfathered" plans (such as the Fund's prescription drug plan), cover a variety of medications and birth control without cost sharing when obtained at an in-network pharmacy. These medications and devices are defined by the United States Preventive Services Task Force and can change and be updated regularly by the government. The Fund will pay 100% of the costs incurred for certain preventive care medications and birth control. **This benefit is limited to the generic equivalent of the prescription or appliance/device.** For preventive prescriptions to be covered, they must be prescribed by a doctor and meet the criteria set forth by ProAct. If a covered item or drug is available over the counter and is covered under this provision,

you must present a prescription at the time of purchase for it to be covered under this plan. All rules pertaining to the prescription drug plan apply, except for the application of the copayment requirements. E.g., if a generic equivalent is available, only the generic will be dispensed without cost sharing. The plan will accommodate any individual for whom the generic equivalent would be medically inappropriate, as determined by the individual's health care provider.

Mandatory Generic Requirement

The Fund follows the mandatory generic substitution requirement. This plan feature limits reimbursement for drugs, which have generic equivalents. Therefore, the following rules apply to prescriptions written for:

- **A brand name drug with no generic equivalent** – you will pay the copayment.
- **A brand name drug with a generic equivalent** – you will pay the copayment, plus the difference in cost between the brand name drug and generic drug. This cost difference can in some cases be substantial.
- **A generic drug** – you will pay only the copayment.

Generic and brand name drugs have exactly the same active ingredients. However, brand name drugs can cost up to seven times more than their generic equivalents. Be sure to ask your doctor to prescribe generic drugs whenever possible. **Remember, if your doctor prescribes a brand name drug and a generic equivalent exists, you will pay the difference in cost in addition to the co-payment. Types of Prescriptions Covered**

1. Prescriptions for legend drugs (drugs, which cannot be dispensed without a prescription) for only the specific use(s) as approved by the Food and Drug Administration.
2. Prescriptions which require compounding and include an approved therapeutic dose of a legend drug.
3. Insulin on prescription.

B. Quantities Permitted – Coverage Restrictions

Retail
Participating Retail Pharmacies are authorized to dispense, when permitted by law, up to

a 30-day supply of medication.

Maintenance Drugs and Mandatory Mail Order – (Home Delivery)
Maintenance prescriptions may only be filled two times at a retail pharmacy. Any maintenance prescriptions needed after the original two fills must be filled through mail order (home delivery). Additional claims at retail will be denied. ProAct Pharmacy is authorized to dispense, when permitted by law, up to a 90-day supply of medication.

Noble Specialty Pharmacy – (Specialty Drug Claims)

All prescriptions for Specialty Drugs, including the first fill and all subsequent refills, must be filled through ProAct's Specialty Pharmacy, Noble Health Services, via mail. The patient will be notified by mail if they are affected by the specialty program. Noble Pharmacy can dispense, when permitted by law, up to a 90-day supply of specialty medication.

Direct Claims

When a direct claim is used, reimbursement is limited to a 30-day supply. All coverage rules apply for direct claims. Maintenance drug direct claims after two fills at retail will be denied with the same restrictions indicated above for maintenance medications.

C. Important Plan Limitations

1. Fertility Drugs

   The cost of fertility drugs are covered, subject to prior authorization requirements, at 50% (member is responsible for a 50% co-payment at point of sale) of the amount that the Fund would have paid for the generic equivalent, if available.

   Note: Some fertility drugs are considered specialty medications and subject to specialty drug protocols and prior authorization procedures discussed in this booklet. Oral fertility drugs (e.g., Clomid) are not considered specialty drugs, but are subject to the Fund's prior authorization requirements.

2. Growth Hormones

   The cost of growth hormone drugs are covered, subject to prior authorization requirements, at 50% (member is responsible for a 50% co-payment at point of sale) of the amount that the Fund would have paid for the generic equivalent, if available.

Note: Growth hormone drugs are considered specialty medications and subject to all specialty drug protocols and prior authorization procedures described in this booklet.

3. Step Therapy

Prescriptions for conditions within certain therapeutic categories will be subject to ProAct's Step Therapy Program. Some examples of these categories include drugs for cardiovascular, central nervous system, dermatological, endocrinological and gastroenterological conditions. **This means that the drug your doctor/provider provides may not be covered.** While this program is not intended to replace the advice of your doctor/provider, it provides therapeutically and medically supported alternatives. Please speak with your doctor/provider about prescribing a generic alternative or a different brand name drug in the same therapeutic category to treat your medical condition (i.e., a Step 1 drug). If you or your doctor/provider choose not to change the prescription to a Step 1 drug, then the drug will not be covered by the plan. If you are currently taking a drug subject to the Step Therapy Program, you may continue to take that drug without interruption.

A list of the plan's Step Therapy Programs are available on the Fund's website at UCEofFIT.org/Welfare Fund tab. As these categories can be updated from time-to-time, it is recommended you consult the Fund's website for updates and to discuss the available alternatives with your doctor/provider.

4. Prior Authorization

The Fund covers certain drugs that require special action by you physician before you can have a prescription for them filled by the Fund's prescription drug plan. These drugs all have "PA" next to them on the formulary list, a copy of which is available upon request from the Fund office. For all PA drugs, your physician should call ProAct and may be asked to mail or fax both a letter of medical necessity and a diagnosis to ProAct.

5. Botox

The Fund covers Botox for medically necessary purposes only. Botox for cosmetic purposes is not covered by the Fund's prescription drug plan.

6. Erectile Dysfunction

The Fund covers oral drugs (e.g., Cialis, Viagra) and urethral suppositories for the treatment of erectile dysfunction with a limit of six (6) doses per 30-day period and 18 doses per 90-day period.

Self-administered Injectable drugs purchased at a pharmacy for treatment of erectile dysfunction are also covered with a limit of eight (8) units per 30-day period and 24 units per 90-day period. Injectable drugs administered in a physician's office or other medical facility are not covered.

7. Tobacco Use Cessation

All FDA approved tobacco use cessation products (including those only available with a prescription and those available over the counter without a prescription) are covered without prior authorization for a maximum 168-day supply for one year of treatment, only when prescribed by a healthcare provider. Coverage includes generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system, brand Nicotrol NS (nasal spray), and generic Zyban.

8. Maximum Out of Pocket Expense

Under the plan, participants have a calendar year out of pocket maximum for covered prescription drugs at in-network retail and/or mail order pharmacy (combined), which is established by the federal government (Department of Health and Human Services) and subject to change each year. The Out-of-Pocket Maximum is the most you pay during the calendar year before the plan starts to pay 100% for covered prescription drug benefits received from in-network pharmacies. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan. For calendar year 2022, the annual out of pocket maximum is $8,700 for an individual and $17,400 for families. The amount of the Out-of-Pocket Maximum may be adjusted annually, in an amount as published by the Department of Health and Human Services.

D. Exclusions (Prescriptions Not Covered)

1. Direct Claims for prescription drugs will not be honored if they are presented for payment later than 90 days from the date on which the drug was dispensed.

2. Drugs, including vitamins, foods, diet supplements, formulas etc. which legally can be purchased without a prescription are not covered, even if a written prescription is obtained from a health care provider. This exclusion does not apply to certain vitamins and supplements that are required to be covered by the Federal Affordable Care Act, provided a prescription is obtained from a healthcare provider (e.g., calcium supplements, prenatal vitamins, children's vitamins with fluoride, folic acid).

3. Appliances and all companion devices for the administration of drugs such as hypodermic syringes, needles, etc., are not covered.

4. Prescriptions not dispensed by licensed pharmacists are not covered except under certain circumstances when provided by a hospital or physician.

5. Experimental and investigational drugs are not covered.

6. Drugs to treat conditions for which there would be coverage through a member's basic medical plan (often referred to as "J-Code" drugs), including but not limited to drugs to treat hemophilia and hereditary angioedema.

7. Drugs for which FDA has granted "orphan drug" designation to prevent, diagnose and treat a rare disease or condition.

8. Drugs Specifically prescribed for weight loss are not covered.

9. Prescriptions filled in a foreign country, with the exception of those filled through the voluntary CanaRx program described in this booklet, are not covered unless required by a covered person in an emergency, and then, only to the extent not otherwise covered by the patient's basic health plan.

10. Dental fluoride products are not covered with the exception of children's vitamins with fluoride.

11. Prescription cosmetic agents, such as hair growth agents and photo-aged skin products, are not covered.

12. Erectile Dysfunction agents are not covered, unless prior authorization is granted. See specific section of this booklet on coverage of Erectile Dysfunction.

13. Miscellaneous blood products are not covered.

14. Rho D Immune Globulin is not covered.

15. Serums, toxoids, and vaccines are not covered.

16. Diagnostic agents are not covered.

17. Medications used for intravenous administration are not covered.

18. Drugs prescribed for “off label” use are covered at the discretion of the prescription benefit manager, after review.

How are Benefits Obtained

A. ProAct Participating Pharmacies

1. Rx Plan Plastic Identification Card (I.D. Card):

Each covered member is issued an I.D. Card authorizing any Participating Pharmacy to fill prescriptions which come under the scope of the plan as specified above. The I.D. Card will certify your eligibility to the Participating Pharmacy. The plastic card will be embossed with your name only. Eligible dependent children up to age 26 will be included (see page 9). If an additional card is required for a dependent boarding at college, or residing with a non-member/custodial parent, contact the Fund.

New members will automatically be issued a card at the completion of the 30-day waiting period, provided that a properly completed Fund Enrollment Form had been previously submitted to the Fund. It is your responsibility to update all dependent information by submitting a Change of Address, Marital Status, and Dependents Form to the Fund Office.

b. Using the Plastic I.D. Card:

Present your prescription and your I.D. Card (with the patient's name embossed on the card) to a Participating Pharmacy; the cost (subject to quantity limitations) will be covered as the above rules state.

2. Refills:

Refills authorized on the original prescription can be obtained (subject to the quantity and time period limitations) by presenting your I.D. Card

together with the Rx number to the Participating Pharmacy that filled the original prescription. Each refill is also subject to the applicable co-payment. Maintenance medications are limited to two fills through a retail pharmacy before they must be obtained through the ProAct Pharmacy.

All prescriptions for Specialty Drugs, including the first fill and all subsequent refills, must be filled through ProAct's Specialty Pharmacy, Noble Health Services, via mail.

3. Locations of Participating Pharmacies:

If you need to locate a ProAct pharmacy, contact the Fund Office (B902) or access the list by visiting ProAct.com. ProAct has many Participating Pharmacies located throughout the United States.

B. Direct Claims

If you present a prescription to a non-participating pharmacy or to a participating pharmacy without your I.D. Card, or if the prescription is for a non-listed dependent, the pharmacist is not obligated to fill your prescription without cost. In addition, the pharmacist is at liberty to charge the pharmacy's regular price, and you are required to pay for it. In this case, in order to receive any reimbursement, you must submit a ProAct Direct Reimbursement **Form** (one for each prescription). You must complete and sign the member's section (upper half) and either have the pharmacy complete its section (lower half) or attach your paid itemized receipt. Direct Claims are subject to all coverage rules and are available in the union office or on our website uce-fit.org under the Welfare Fund Tab.

The completed form should be mailed to:

ProAct Pharmacy Services
1226 US Highway 11
Gouverneur, NY 13642-9926

Reimbursement will be made in accordance with the Schedule of Allowance that is applicable to Participating Pharmacies, as well as the generic stipulation explained above. This will most likely result in an out-of-pocket expense to you, which may exceed plan co-pays.

C. How to Obtain Claims Information

For information regarding benefit explanations or claim reimbursements contact ProAct. ProAct can be reached on online at www.ProActRx.com or

Support@proactrx.com or by telephone (877) 635-9545

D. The ProAct Mail Order Pharmacy – Gouverneur, NY

The Fund now mandates the use of the ProAct Pharmacy for all maintenance medications after two original fills at the local pharmacy. Using the mail order program means fewer trips to the pharmacy particularly if you use maintenance drugs or need to purchase a three-month supply of drugs. In both cases, the cost to you and the Fund will be lower. The mail order co-payments are as follows:

$40 Generic
$60 Preferred Brand
$100 Non Preferred Brand

The drugs will be mailed directly to your home. The ProAct Pharmacy will pay the postage.

If your prescription is for a brand-name drug, and a generic is available, or if you are uncertain as to whether a generic is available, the Fund advises you to telephone ProAct to ascertain the difference in cost (if applicable) between the two. Include this amount with your co-payment in the mail order envelope as outlined below.

If your prescription is for a generic drug, all you have to do is mail your prescription with your eligibility number (printed on your I.D. card) and your co-payment to:

The ProAct Pharmacy

Pre-printed ProAct Forms are available in the Fund Office (B902) or on our Website - www.uce-fit.org under the Welfare Trust Fund tab.

ProAct will first check to make sure that no reason exists why you should not be taking the prescribed medication, e.g., drug interaction(s). If there is a question, a ProAct pharmacist will contact you or your doctor for more information.

If the medication is approved, ProAct will complete your order and mail it to you. Refills can be ordered through the web site address, call center phone number or IVR option and should be requested three weeks before your medication is due to run out.

If you have a question or problem with a mail order prescription, call ProAct at 1-866-287-9885

E. The Noble - Specialty Pharmacy

The Fund now mandates all specialty medications be obtained through the Noble pharmacy located at 8001 Route 31, Bridgeport, NY 13030 *www.noblehealthservices.com Tel: (888) 843-2040/FAX: (888) 842-3977*. Noble is a specialty pharmacy, which handles only high cost medications. Members are allowed one fill of a specialty medication at a retail pharmacy. Once the retail prescription is received, Noble will contact you. Each member will be assigned a case manager who will work with you and your doctor to obtain new prescriptions and manage your therapy. Please note, ProAct will follow the mail order dispensing quantities and co-payments.

External Appeal Process

Once you have exhausted the standard internal appeals process described in the General Information section of this booklet, you may ask for a review by an Independent Review Organization (IRO). The details of this process will be contained in any letters you receive from ProAct concerning a prescription drug appeal you filed.

CANARX INTERNATIONAL PHARMACY

UCE of FIT Welfare Trust Fund will make available on a **voluntary** basis to employees and dependents a cost saving **mail order drug program** for *brand name prescriptions* administered by **CanaRx.** This is a voluntary program and not replacing your current prescription benefit plan.

Advantages of joining the UCE of FIT Meds (www.uceoffitmeds.com) program administered by CanaRx are:

- **$0 COPAY** for all prescriptions offered through the program
- Prescriptions shipped directly to your home with no shipping and handling costs
- No out-of-pocket expenses
- Go to www.uceoffitmeds.com for a list of brand name prescription medications available

How does it work?
Review formulary list of brand name prescriptions available online at www.UCEofFITMeds.com to determine if any of your current medications are available through this program

Before ordering through CanaRx, you or your doctor must attest that you have been

taking your prescribed medication for at least 30 days to ensure you do not have any problems with the medication

Ask your doctor for a prescription for a **3-month supply** with **3 refills**
Request your doctor to fax your enrollment form and prescription directly to **UCE of FIT Meds** -Or Mail your original prescription and completed enrollment form to **UCE of FIT Meds**

Include a new prescription for each medication being ordered CanaRx will call you prior to each refill to ensure that you have a continuous supply of medications
Allow 4 weeks for delivery when ordering new medications

CanaRx Contact Information:
Mail **UCEof FIT Meds**, P.O. Box 44650, Detroit, Michigan 48244-0650
Fax 1-866-715-(MEDS) 6337
Phone 1-866-893-(MEDS) 6337

Web **www.UCEofFITMeds.com**
Should you have any questions regarding the **UCE of FIT Meds** program, please call the CanaRx toll free phone number **(1-866-893-6337)** with your questions.

Remember… this is a voluntary program and not replacing your current prescription benefit plan

DENTAL PLAN

WHO IS COVERED:

All eligible members and dependents as defined in the "General Information" section (pages 8 - 10) are covered for dental benefits.

PLAN MAXIMUMS:

Dental - $3,000 per covered individual in a calendar year.

Orthodontics – $2,220 lifetime maximum benefit per covered individual. Coverage includes up to a maximum of 24 months of active treatment at the scheduled reimbursement and 9 months of passive treatment at the scheduled reimbursement. Benefits for Orthodontic treatment are included in the annual maximum.

ANNUAL DEDUCTIBLE:

Effective January 1, 2013, there is a $50 deductible per covered individual. The annual deductible is waived for diagnostic and preventive services.

COVERED EXPENSES:

Covered Expenses include charges incurred for the performance of Dental Services provided for in the **UCE of FIT WELFARE TRUST FUND Dental Schedule**, when the Dental Service is performed by or under the direction of a duly licensed Dentist, is essential dental care, and begins and is completed while the individual is covered for benefits. A copy of the **Dental Schedule** can be obtained on the *www.asonet.com* website.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- for a crown, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

HOW TO FILE A CLAIM:

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

S.I.D.S. / A.S.O., Dept.13
P.O. Box 9005
Lynbrook, NY 11563
516-396-5500/718-204-7172

Claim Forms are available from the Fund Office S.I.D.S/A.S.O. You can also obtain claim forms from the S.I.D.S. website at www.asonet.com . Dental and the Fund website: www.uce-fit.org under the Welfare Fund tab. Claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed. If you would like the payment made directly to your Dentist, you may do so by signing the "Authorization to Assign Benefits" box on the claim form. Reimbursement will be at the rate of 100% of the fees listed in the **Schedule of Covered Dental Expenses**, not to exceed actual Dentists charges.

EXTENSION OF BENEFITS:

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, fixed bridgework and full or partial dentures, a Pre-treatment Review Estimate was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after that person's eligibility terminated.

- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not indicated above.

PRE-TREATMENT REVIEW:

This process is intended to inform you and your dentist, in advance of treatment, what benefits are provided by the Dental Program. It enables you to obtain full knowledge of

the operation of your dental plan prior to undertaking treatment and incurring expenses.

A Claim Form for Pre-treatment Review Estimate should be filed by your Dentist if the course of treatment prescribed for you is expected to cost more than $500 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery. The Dentist should complete the claim form, describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary x-rays and other supporting documentation to:

S.I.D.S. / A.S.O., Dept.13
P.O. Box 9005
Lynbrook, NY 11563
www.asonet.com

S.I.D.S. / A.S.O. will review the proposed treatment and apply the appropriate Plan provisions. You and your Dentist will receive a report showing the exact amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your Dentist. If you receive a Pre-treatment Review Estimate for a proposed course of treatment that was submitted by one Dentist, that Pre-Treatment Review Estimate will remain valid if you elect to have some or all of the work done by another Dentist. The Pre-Treatment Review Estimate will be honored for one year after issuance.

Please be aware that a Pre-treatment Review Estimate is not a promise of payment. Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits) and no significant change occurred in the condition of your mouth after the Pre-Treatment Review Estimate was issued. Payment will be made in accordance with plan allowances and limitations in effect **at the time services are provided**.

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 produce a suitable result based on accepted dental standards. In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive Alternate Course of Treatment. This should in no way be considered a reflection on your treating dentist’s recommendations. By using the Pre-Treatment Review Estimate procedures you and your Dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a Pre-Treatment Review Estimate, the benefits paid by the Dental Plan may be based on the less expensive treatment.

COSMETIC LIMITATION:

Where there is more than one method of restoring a decayed or fractured tooth, one of which may result in a more aesthetic restoration than others, payment will be based on the least costly professionally acceptable treatment option.

EXPENSES NOT COVERED:

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

1. treatment solely for the purpose of cosmetic improvement.
2. replacement of a lost or stolen appliance.
3. replacement of a bridge, crown or denture within five years after the date it was originally installed.
4. replacement of a bridge, crown or denture which is or can be made usable according to common dental standards.
5. 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 multiple bridge abutments.
6. multiple bridge abutments.
7. a bridge or denture that replaces a tooth that was missing when the individual became eligible for dental benefits under this plan.
8. a surgical implant of any type except for any prosthetic device attached to an implant which is covered subject to the limitations described under “Implantology” below.
9. dental services that do not meet common dental standards.
10. services not included as Covered Dental Expenses in the UCE of FIT Welfare Trust Fund Dental Schedule.
11. 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:

1. for or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party.
2. for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
3. for or in connection with a sickness which is covered under any workers compensation or similar law.

4. for charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance.
5. to the extent that payment is unlawful where the person resides when the expenses are incurred.
6. for charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family.
7. to the extent that they are more than Reasonable and Customary Charges.
8. for charges for unnecessary care, treatment or surgery.
9. 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.
10. for or in connection with experimental procedures or treatment methods not generally accepted in the industry.
11. for any services covered under a "No Fault" policy.

GUARDED PROGNOSIS LIMITATION:

If, in the opinion of the claims administrator, the longevity of the proposed or rendered treatment is limited, payment may be made in accordance with Plan provisions. However, any future benefits for additional services may be affected.

IMPLANTOLOGY:

Payment for a prosthetic device that is attached to one or more implants will be based on benefit allowances that would be paid if no implant was placed. Implants are not a covered benefit.

Self-Insured Dental Services Participating Dental Program

This feature of your dental plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental bill. Since usual and customary dental charges generally exceed Dental Plan reimbursements, you will realize a significant savings in the cost of your dental care when you use a participating provider.

When you use a participating provider you will not incur any out-of-pocket expenses except in the following instances:

1. For services that are listed in the Schedule but for which the Plan will not pay, e.g.:
   a) where dental plan benefits exceed maximums.
   b) where procedure frequency limitations have been met.
   c) to satisfy the deductible, where applicable.

In these instances, the participating dentist's fees may not exceed the Maximum Charges as stated in the Schedule.

2. For non-covered services (there are a few procedures not covered by the Plan), you are not to pay more than the dentist's usual and customary fee for that service.

You should be aware that although several dentists may practice at the same location, only the dentist whose name appears on the list is a UCE of FIT Welfare Trust Fund Participating Dentist.

SELECTING A DENTIST:

There are no restrictions on the use of a participating dentist. You are free to select the dentist or dental specialist of your choice. And of course, each family member may select his or her own dentist. You may utilize the services of a participating specialist whether or not you utilize the services of a participating general dentist for your routine care. You may change your dentist at any time for any reason. It is important to understand that the Fund does not recommend or endorse any particular dentist. You are responsible to select the dentist of your choice, participating or non-participating, and you should exercise the same care and apply the same criteria in selecting a participating dentist that you would in selecting a non-participating dentist.

SCHEDULING AN APPOINTMENT:

After selecting a dentist from the directory, call the dental office for an appointment. Identify yourself as an eligible member of the UCE of FIT Welfare Trust Fund when scheduling your appointment. **Due to the fact that there are occasional additions and deletions, please verify that the dentist is still participating when scheduling your appointment. If you have any questions, please contact Self-Insured Dental Services at: 516-396-5500 / 718-204-7172. Please feel free to access their web site at www.asonet.com.**

FILING A CLAIM:

Participating dentists will handle all the necessary paperwork. You simply complete the Member Information and Assignment of Benefits section of your claim form and payment will be made directly to the dentist. You will be responsible for paying the dentist only in those instances stated above.

OPTICAL REMBURSEMENT PLAN

The Fund's optical reimbursement plan is administered by the Fund Administrator, Seneca Consulting Group, Inc. tel. (1-866) 487-4157, e:mail: dan@thesenecagroup.com.

Who is Covered

You and your eligible dependents, as defined in the "General Information" Section (pages 8 -10), are covered for optical benefits.

What are the Benefits

Under the optical reimbursement plan, the Fund pays a benefit allowance of up to $100.00 on a rolling 12 month basis for each member and eligible dependent that receives the following services, which must be rendered by the licensed optometrist of opthamologist of your choice:

- Eye examinations (should not be used for co pay for Aetna services)
- Lenses and or contacts
- Frames

Limitations

Charges in excess of above allowance are the responsibility of the member.

How to Obtain Benefits

1. To apply for benefits you must obtain an Optical claim form from the Fund Office, B902 or on the UCE-FIT.org website under the Welfare Fund Tab.

2. Send the completed claim form to Seneca Consulting Group with an original, dated receipt, marked “paid”, describing the type of service rendered, the date the service was rendered, the amount charged and the name of the person who received the optical services. The receipt must also show the name, address and telephone number of the provider.

3. Optical claims must be filed within 12 months after the date of service. Claims filed later than 36 months from the date of service will not be reimbursed.

Exclusions:

1. Non-prescription sunglasses.

2. Services provided by a member of your or your spouse’s/domestic partner’s immediate family.

HEARING AID REIMBURSEMENT PLAN

The Fund's hearing aid reimbursement plan is being administered by the Fund Administrator, Seneca Consulting Group, Inc. Telephone Number: 866 487-4157, e:mail: dan@thesenecagroup.com.

Who is Covered

You and your eligible dependents, as defined in the "General Information" Section (pages 8-10), are covered for hearing aid benefits.

What are the Benefits

Under the hearing aid reimbursement plan, the Fund pays a total benefit allowance (for both ears) of up to $500.00 on a rolling 5-year basis for each member and eligible dependent for charges for the following services, which must be rendered by the licensed physician, otologist or audiologist of your choice:

- Hearing aid appliances;
- Hearing analysis, tests or evaluations

How to Obtain Benefits

1. To apply for benefits you must obtain a hearing aid reimbursement claim form from the Fund Office, B902 or on the UCE-FIT.org website under the Welfare Trust Fund Tab.

2. Send the completed claim form to Seneca Consulting Group, with an original, dated receipt, marked "paid", describing the type of service rendered, the date the service was rendered, the amount charged and the name of the person who received the services. The receipt must also show the name, address and telephone number of the provider.

3. Hearing aid claims must be filed within 36 months from the date of service. Claims filed later than 36 months from the date of service will not be reimbursed.

Exclusions

1. Expenses not recommended or approved by a physician or otologist.

2. Expenses for which benefits are payable under any Workers'

Compensation Law.

3. Benefits payable under Medicare or any other governmental plan.

4. Nondurable equipment, such as batteries.

5. Special procedures or training such as lip reading courses, schooling or institutional expenses.

6. Medical or surgical treatment of the ear or ears.

7. Charges for services or supplies, which are covered in whole or in part under any other Fund benefit.

8. Charges for repair of hearing aid appliances.

ACCIDENT AND SICKNESS DISABILITY PLAN

Who is Covered

All eligible (active, full-time) members are covered for benefits under the Fund Accident and Sickness Disability Plan.

What are the Benefits

The Accident and Sickness Disability Plan provides income to you should you become disabled. The benefit is one-half of the employee's day wage to a maximum of $87.50 per day for a maximum period of 28 weeks.

The disability benefit is payable only under the circumstances and in accordance with the procedures and limitations set forth in the Rules and Regulations that follow.

Rules and Regulations

If you become disabled, the Fund, following a waiting period of seven consecutive days, will pay benefits in the amount and for the period specified below:

A. Disability Defined

Disability shall mean only that period during which you are prevented from performing the duties of your employment in any occupation, or employment as a result of injury or mental or physical illness as determined by the Fund.

The Fund has found that not all employees who apply for disability benefits are actually disabled. Therefore, you must provide the Fund with written documentation provided by the College approving your leave for medical reasons.

All claimants may be subject to examination(s) by a designated physician, at the expense of the Fund, and shall furnish such proof of illness or injury as the Fund Office shall, in its discretion, direct.

In the case of pregnancy-related disability, experience has shown that disability as defined above usually occurs during the ninth month of pregnancy and in the six weeks immediately following the delivery.

Therefore, examination by a designated physician will not be required during those periods. If pregnancy-related disability is claimed for any other period, the usual rules described above regarding examination will be followed.

B. Waiting Period Defined

After you have exhausted your Personal Sick Bank under the Rules and Regulations of the Collective Bargaining Agreement, and have been removed from the FIT payroll, the waiting period of seven consecutive working days begins.

C. Amount Payable Defined

Subject to the exclusions and limitations set forth below, the amount payable is as follows:

- You are eligible for a benefit of one-half of your daily wage to a maximum of $87.50 per day (Monday through Friday)

D. Disability Payment Period Defined

1. Benefits shall be payable commencing with the first day of disability following the expiration of the waiting period as defined in "B" above, but only if you are on authorized sick leave without pay or maternity leave without pay which commences immediately following your removal from the FIT payroll.

2. Disability benefits will continue until the day prior to the receipt or potential receipt of an FIT Long Term Disability (LTD) benefit or the expiration of your leave of absence, whichever occurs first.

3. All periods of disability due to the same or related sickness or injury followed by a recovery and a return to work for periods of less than 40 successive work days, will be considered one continuous period of disability and no benefits will be payable for more than 28 weeks for all such periods combined.

4. A return to work for at least 40 successive workdays after a period of disability shall entitle you to begin a new period of disability of not more than 28 weeks.

5. Benefits for all periods of disability due to the same or related sickness or injury shall not exceed 100 weeks.

E. Exclusions and Limitations

No benefits shall be paid:

1. for any period for which there has not been proper filing as described below;

2. for any period during which pay is received from FIT;

3. for any period during which benefits are paid or payable under any Workers' Compensation law, occupational disease law, or similar legislation of the State or Federal Government;

4. for any period during which benefits are paid or are payable under any unemployment compensation or similar laws;

5. for any period during which you are not under the care of a legally licensed physician for the condition causing the disability;

6. for any period of disability which does not commence while you are covered under the Fund rules of eligibility;

7. for any period of disability due to willfully and intentionally self-inflicted injury or sickness, or to injury sustained in the commission of a crime;

8. for any period during which pension is received from any governmental retirement service;

9. for any period during which benefits are paid or payable under the New York State or other jurisdiction's No-Fault Insurance Law (this exclusion is not applicable after No-Fault benefits are exhausted; a letter from the no-fault insurance carrier confirming this must accompany your DBL-1 initial application for benefits);

10. for any period for which reimbursement may be obtained from any other third party, such as by way of litigation arising out of an accident, or otherwise, unless a written assignment or lien in a form acceptable to the Fund is executed by you to the Fund for the

amount claimed.

How are Benefits Obtained

1. When you have been disabled for a period of seven consecutive days, or if you know that you will be disabled for a period of seven consecutive days or longer, you should request a disability claim form from the Office of Personnel Administration.

2. There are two types of claim forms in connection with this benefit:

   "DBL #1 - Initial Application" and
   "DBL #2 - Supplemental Application."

   It is your responsibility to make sure that each part of the claim form has been completed by you, the Office of Personnel Administration and your physician as required, that you have signed the affidavit on the reverse side, and that all the necessary documents have been forwarded to the Fund Office. Incomplete claims will be returned to you, thus delaying your benefit payments. Photocopies of any of the claim forms are not acceptable.

3. Your first claim (DBL #1 - Initial Application) must be filed no later than 60 days following your seven day waiting period, or 60 days following the issuance of your Leave, whichever is later. Failure to file within this period may result in the loss of benefits for the period between the seventh day of disability and the date the claim is received by the Fund Office. (Physical inability to file within this period, or similar extraordinary circumstances, will be considered an exception to this requirement.)

4. Upon receipt of a properly completed and signed claim form, with the necessary documentation attached, the Fund will review the claim.

5. If, after having received a disability benefits payment from the Fund, you wish to apply for further disability benefits, use the claim form marked, "DBL #2 - Supplemental Application," which was enclosed with your benefit check. You should make application for continued benefits no later than 60 days following the last date of the previous Fund Disability Payment, so as not to jeopardize additional benefits.

HEALTH ADVOCATE PROGRAM

The UCE of FIT Welfare Trust Fund has retained the services of Health Advocate, Inc. to provide a Program designed to help you and your families handle healthcare and insurance related issues by cutting through the red tape and barriers that so often create frustration and problems.

Who is covered

Health Advocate will provide services to all eligible, full-time, active members of the UCE of FIT Welfare Trust Fund as well as the Eligible Member's spouse/domestic partner, dependent children, parents and parents-in-law (collectively referred to in this section as "Eligible Members").

What are the benefits

Health Advocate does not deliver medical care nor tell Eligible Members what to do. Instead, they help you and your families make more informed decisions about health care. A Personal Health Advocate, typically a registered nurse will answer your questions, do the research, provide you the options and follow up with you.

The following services are provided to Eligible Members:

The Personal Health Advocate is typically a Registered Nurse, assigned to serve the subscriber as soon as he/she calls to access Services. Personal Health Advocates handle a range of issues as Eligible Members seek healthcare services and interact with providers and insurers.

- **24/7 HelpNet**: Health Advocate's business hours for reaching a live person are 8:00 a.m. to 7:00 p.m. Eastern Standard Time. After hours, Eligible Members can leave a message and Health Advocate will return the call the next business day. In a non-medical emergency, Eligible Members may use the beeper number provided to page an "on-call" Health Advocate representative.

- **Care Coordination**: The Personal Health Advocate helps Eligible Members coordinate care among physicians and medical institutions.

- **Medical Director and Administrative Support:** Physicians and administrative staff support the Personal Health Advocates.

Benefits Advantage™

- **Claims Assistance:** Personal Health Advocates help sort out and solve claims and related paperwork problems and assist Eligible Members with coverage and benefits issues.

- **Fee Negotiation**: When necessary, Health Advocate can attempt to negotiate fees with healthcare providers and review questionable bills to catch duplicative and/or erroneous charges.

- **Grievance Advice**: Health Advocate will provide advice and/or assistance to Subscribers when filing a complaint or grievance. However, any costs and expenses incurred by Health Advocate in connection with representation at appeals hearings will be billed directly to the Eligible Member, at an hourly rate.

- **Coverage Advantage™**: The Personal Health Advocate can help Eligible Members through the coverage review process. They can also assist in identifying alternative coverage options when necessary.

- **RxAdvocate™:** The Personal Health Advocate can assist Eligible Members with prescription drug issues including formulary and benefit questions.

Physician Locator: Personal Health Advocates can help Eligible Members identify physicians, hospitals, dentists and other healthcare providers for needed services.

Advocates of Excellence: Personal Health Advocates can help identify top medical institutions, Centers of Excellence and medical providers to assist Eligible Members in need of complex medical care. Our Personal Health Advocates can also help Eligible Members schedule appointments with these providers, as required.

Health Advocate CareQuest: This Service locates resources and makes arrangements for Eligible Members in need of special services that typically fall outside the realm of traditional healthcare benefits. The Eligible Member is responsible for payment for any services that they use beyond what may be covered by their health insurance plan.

How are benefits obtained

Simply call Health Advocate at 1-866-695-8622. There are no enrollment forms. When you call, Health Advocate and require service, they will ask you to complete a Medical

Information Release Form. Please be assured that all your information will be kept strictly confidential by Health Advocate and your privacy will be protected.

Limitations on Health Advocate's Role

Health Advocate recognizes that the Eligible Members are covered under a self-insured, employer provided employee medical health plan. A Personal Health Advocate may intervene on behalf of Eligible Members with respect to said self-insured health plan. However, Health Advocate may not engage in representation of an Eligible Member before any joint labor/management committee which oversees the administration of the plan, except for assistance in preparation of the appeal and supporting documents. Health Advocate may assist Eligible Members in writing a letter of appeal to the health plan; however, appeal letters must come directly from the Eligible Members and may not be submitted by Health Advocate on its letterhead.

LEGAL SERVICES PLAN

"(The assistance of counsel) is one of the safeguards of the Sixth Amendment deemed necessary to ensure 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 United College Employees of Fashion Institute of Technology Benefit Trust Fund benefits, as a full-time employee of the Fashion Institute of Technology as defined in the “General Information” Section (pages 8-10), you are eligible for legal services benefits.

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 UCE of FIT Welfare Trust Fund Enrollment Form. The Enrollment Form provides the Fund with necessary basic information: your name, address, Social Security number, birth date, marital status, etc.

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 of the UCE of FIT Welfare Trust Fund adopts rules and regulations for the payment of benefits and all provisions of this plan 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 in

accordance with the rules pertaining to appeals on page 13 of this booklet.

HOW TO USE THE LEGAL SERVICES PLAN – THE PANEL LAW FIRM SYSTEM

If you wish to make an appointment to consult a lawyer for benefits provided, call 212-217-3370

You will be provided with an attorney from a panel law firm selected by the Fund. This firm will provide you with the benefits of the 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 employee 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 you have, 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. 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 required to make the 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 to make payment to such attorney for services. However, the Fund will not absorb nor 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 non-panel attorneys. In addition, you continue to be obligated to the panel law firm for any cost 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, you are free to secure your own counsel. However, the Fund will neither absorb, nor be responsible for, any of the fees or charges of a non-panel attorney.

If you are an active member, you do not have to pay any subscription or registration fee to obtain the benefits of the Fund.

Member versus member disputes - In instances where two covered members are involved in the same controversy or proceedings 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, as determined by the Board of Trustees.

GEOGRAPHIC AREAS COVERED

Covered full-time employees of FIT residing within the geographic areas* covered by the plan – receive legal services through the panel law firm without consideration of hours expended. You simply pay a small “deductible” for some services (others are provided at no cost to you).

**The geographic area covered by the plan includes; the five boroughs of New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange and Ulster counties in New York and Bergen, Essex, Union, Hudson, Middlesex, Passaic, Morris, Somerset, Mercer, Sussex, Warren and Hunterdon counties in New Jersey.*

Members who reside in Connecticut will be covered for the preparation of wills only.

Covered full-time employees residing outside the geographic areas covered by the plan – receive legal services through a “hybrid plan”, under which certain services are covered by the firm and others through the payment of a stipend. You are entitled to a maximum reimbursement up to $1,000 per year, per family. In order to receive benefits, the out of area employee/faculty member must pay their attorney and then submit a claim form together with a copy of the paid bill to the panel law firm.

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 three Representation in Civil Matters, each year. 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.*

**Please note that special service benefits such as those involving divorce proceedings, separation proceedings, annulment proceedings, and homeowners proceedings are covered by the schedules contained under those specific headings 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 Rockland, Orange, Putnam, Dutchess, New York, Brooklyn, Queens, Richmond, Bronx, Nassau and Suffolk Counties Civil Courts of New York, Brooklyn, Queens, Richmond and Bronx Counties; District Courts of Nassau and Suffolk Counties and Northern New Jersey; Administrative Agencies and Bureaus.

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.

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

	Steps in the Legal Process Provided by The Fund through the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	None
B.	Pre-litigation: Including for example negotiation of settlement including the drafting of any necessary papers	$15

C. Litigation: Including, for example, Third Party Complaint, Demand for Bill of Particulars, preparation of Jury Demand and court appearance, if necessary $35

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 the member is $15; if the Legal Defense Benefit must enter the litigation stage, the cost to the member is an additional $35. Hence, the total cost to the member for a Legal Defense Benefit that reaches litigation is $50 ($15 + $35).

How to Obtain the Benefit . . . . 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.

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 though 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 the member in each circumstance:

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

A. Consultation None

B. Uncontested or cooperatively agreed separation with minimal negotiation $45

C. Settlement after extensive negotiation $75

Where the parties do not wish to enter into a separation agreement, an uncontested action in court for a legal separation may be had.

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

Steps in the Legal Process Provided by The Fund through the Panel Law Firm	**Amount Paid by Fund Member**
A. Consultation	None
B. Litigation: including, for example, conference, preparation of Summons and Verified Complaint, documents relating to maintenance and support of children (in proper instances), Findings of Fact and Conclusions of Law.	$180

How to Obtain the Benefit . . . . To obtain the Uncontested Legal Separation 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 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 in each circumstance:

Steps in the Legal Process Provided by The Fund through the Panel Law Firm

A. The member is entitled to ten hours of legal representation, in negotiating a divorce settlement until litigation must commence in instances where the panel attorney determines that litigation is necessary in order to maintain, defend, advance or assert the member's interest. (See "B" below)

A divorce action will be initiated under this benefit when:

1. The member and spouse have agreed upon an uncontested divorce and no stipulation of settlement is required; or

2. The member and spouse had previously signed a separation agreement or stipulation of settlement and have agreed upon an uncontested divorce; or

3. The member requests representation in negotiating a stipulation of settlement (e.g., equitable distribution, child support, custody, visitation and maintenance) and the spouse has retained an attorney. A stipulation of settlement is then negotiated and executed, grounds are agreed upon and the spouse signs an affidavit agreeing upon the grounds for divorce.

Amount Paid by Fund Member $60.00

B. The member may (in addition to “A” above) retain the services of the panel law firm after the first ten hours of legal representation or once litigation is necessary to commence, subject to a written agreement of retention.

Amount Paid by Fund Member HOURLY

The panel law firm has agreed to provide said representation under B. with a 25% reduction in its hourly rate, which hourly rate has been established as $450 for calendar year 2022. (This is $337.50 for 2022, but subject to change in subsequent years.)

How to Obtain the Benefit . . . . To obtain the Uncontested Divorce Proceedings 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 the category of uncontested annulment proceedings.

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

Steps in the Legal Process Provided by The Fund through the Panel Law Firm	Amount Paid by Fund Member
A. Consultation	None
B. Uncontested Annulment - Coverage includes, for example, Summons and Complaint, Note of Issue, preparation of Findings of Fact, Conclusions of Law, entry of Judgment	$60

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.

What is the Benefit.... The Fund will provide a covered member with an attorney from a panel law firm to represent the member 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 the member in each circumstance:

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

A.	Consultation	None
B.	Preparation of Documents and Court Appearance for adoption of child	$65

How to Obtain the Benefit.... 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 Eligible.... Any covered member is entitled to this benefit.

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 the member in each circumstance:

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

A.	Consultation	None
B.	Simple Personal Bankruptcy	$75
C.	Complex Personal Bankruptcy	$100

How to Obtain the Benefit.... 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.

<u>CHANGE OF NAME BENEFIT</u>

Who is Eligible.... Any covered member is entitled to this benefit.

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 the member in the change of name process.

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

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

A.	Consultation	None
B.	Actual change of name procedure	$45

How to Obtain the Benefit.... 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’S RIGHTS BENEFIT

Who is Eligible.... Any 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:

(1) 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 unimproved property with the intention of building a home in which the member expects to primarily reside or the refinancing of a mortgage on a primary residence.

(2) 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 the member in each instance:

Steps in the Legal Process Provided by The Fund through the Panel Law Firm	Amount Paid by Fund Member
A. Consultation	None
B. Negotiation, advice and representation in the sale, purchase or refinance of a primary residence	$60.00

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’s Rights Benefit is legal representation through the panel law firm attorney in defense of a proceeding to foreclose a mortgage on a dwelling which the member owns and in which the member primarily resides. 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 Amount Paid by The Fund through the Panel Law Firm Fund Member

A.	Consultation	None
B.	Pre-litigation: including, for example negotiation of settlement as well as the drafting of any necessary papers	$15
C.	Litigation: including, for example, Demand for Bill of Particulars, preparation of Jury Demand, Motions and court appearances	$125

How to Obtain the Benefit.... To obtain the Homeowner's 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 benefits of the Legal Services Program are divided into two categories: Representation in Civil Matters and General Legal Matters.

This section describes the General Legal Matters of the program. These benefits are provided to the members in those instances where the member's 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 Eligible.... All covered members are entitled to this benefit.

What is the Benefit.... This benefit provides covered members 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 a covered member.

How to Obtain the Benefit.... 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.

**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 the member.*

DOCUMENT REVIEW BENEFIT*

Who is Eligible.... Any covered member is 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, by an attorney from the panel law firm. There is no frequency limitation placed upon the utilization of this benefit, which is provided at no cost to the member.

Exclusions and Limitations:

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

A. Tax Returns

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

** 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 the member.*

How to Obtain the Benefit....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 covered member and his/her spouse, if agreeable to the member, are entitled to this benefit. In addition, the parent(s) and/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 will, with a simple children's trust if appropriate, for the member, his/her spouse (if agreeable to the member), the member's parent(s) and/or parent(s)-in-law under the supervision of an attorney from the panel law firm. The benefit is provided without charge, not more than once in every consecutive year period.

How to Obtain the Benefit.... To obtain the Will Benefit, simply contact the Fund to request an appointment. At the time of the appointment, the appropriate forms will be completed. A second appointment will be scheduled for the execution (signing) of the completed will(s).

PERSONAL INJURY (NEGLIGENCE) BENEFIT

Who is Eligible....A member and/or all members of his/her immediate family who has suffered a personal injury as a result of negligence is covered by this benefit.

What is the Benefit.... The Legal Services Program provides coverage through the panel law firm for all legal services, through trial if necessary, in connection with the prosecution of a claim for personal injury as a consequence of negligence in cases which legal counsel believes are worthy of prosecution. The member will be represented on the basis of a contingent fee of 33-1/3% of the net sum recovered.

What Does "Contingent Fee" Mean.... It means that the fee is contingent upon successful recovery, whether by suit, settlement or otherwise. Thus, if there is no recovery, there is no fee. Conversely, the more that is recovered, the greater the fee...all dependent upon a successful conclusion of the matter.

As customary, whether the litigation is successful or not, you are required to reimburse the firm for all disbursements, charges and other expenses, such as: medical and police reports, investigations, witness fees, etc. Also, as is customary, in computing this contingent fee, liens in favor of hospitals, doctors, etc. or other statutory liens upon recovery, are not to be deducted. Such amounts would be paid out of the injured party's share of the recovery.

How is the Personal Injury (Negligence) Benefit Obtained...To obtain the 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.... Any covered member or dependent who is a defendant in a criminal proceeding in Nassau, Suffolk, Westchester, Putnam, Dutchess, Rockland or Orange Counties, or the five boroughs of New York City.

What is the Benefit.... The benefit provides coverage through the panel law firm for necessary legal assistance by telephone consultation arising from an arrest which may lead to immediate imprisonment.

This benefit provides, for example, the legal defense cost of telephone assistance by an attorney, where the member/dependent is 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 the arraignment telephone consultation stage. Thus, if the member/dependent is interested in obtaining legal services beyond the arraignment stage, he/she must make the necessary arrangements directly with the panel law firm or retain another attorney of his/her choice.

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

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

A. Consultation None

How to Obtain the Benefit.... To obtain the Arraignment Assistance - Telephone Consultation Benefit, the Fund must be contacted so that the appropriate arrangements may be made by the Fund with the panel law firm.

This service is available at any hour of the day or night by calling the special Fund number assigned to the program. **516-466-6030**

CONSUMER PROTECTION BENEFIT

Who is Eligible.... Any covered member is entitled to this benefit.

What is the Benefit.... This benefit provides members 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 the member in each circumstance:

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

	Steps in the Legal Process	Amount Paid by Fund Member
A.	Consultation	None
B.	Representation by Written Communication	None
C.	Litigation in Small Claims Court	$50
D.	Litigation in Courts other than Small Claims Court	$100*
E.	Representation with Appropriate Federal Agencies (e.g. F.T.C., etc.)	$100*

**If a lawsuit involves a consumer purchase of $5,000 or more - e.g., “Lemon” car - then the cost to the member for litigation or representation shall be $250.00*

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

How to Obtain the Benefit.... 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 Benefit 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 Benefit 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 Benefit 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.

LIVING WILL/HEALTH CARE PROXY/POWER OF ATTORNEY BENEFIT

Who is Eligible. . .You are eligible if you are a covered member, a covered member's spouse (if agreeable to the member) or domestic partner or a covered member's parent(s) and/or parent(s)-in-law.

What is the Benefit. . .This benefit provides you, your spouse or domestic partner, your parent(s) and/or parent(s)-in-law with the opportunity to have a living will/health care proxy/power of attorney prepared and executed under the supervision of an attorney from the panel law firm. This benefit is provided once every two plan years at no cost to you. Adult children of members will also be covered for the preparation of health care proxies and powers of attorney, provided the parent/member is designated as the proxy or attorney in fact.

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 is a document by which one person, known as the Principal, appoints another as his or her Agent, known as an Attorney-in-Fact and conders upon that Agent certain power and authority as set forth in the Power of Attorney. It can remain effective if the Principal becomes disabled and can no longer handle his/her affairs – this is known as a Durable Power of Attorney.

How to Obtain the Benefit.... To obtain the Living Will/Health Care Proxy/Power of Attorney Benefit, either you or your spouse or domestic partner should contact the Fund to request an appointment. If both husband and wife desire a living will/health care proxy, it is recommended that they make an appointment together. At the time of the 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.

Note: With respect to a covered member who wishes to be named Designee, or needs

to appoint a designee, an attorney from the panel law firm will provide a special consultation to confirm that the Designation has been drafted in compliance with the law.

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.

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

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

How to Obtain the Benefit.... To obtain the Planning for the Elderly Benefit, either you, your spouse or your domestic partner 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.

ESTATES AND ADMINISTRATION BENEFIT

Who is Eligible.... You are eligible if you are a covered member or a covered member's eligible dependent who is named as Executor in a Will. You are also eligible if you are named as executor in a will by a covered member. If there is no Will, you or an eligible dependent who would qualify under intestacy laws to serve as Administrator of the estate will be eligible.

What is the Benefit.... This benefit 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 accounting and distribution).

With respect to the estate of a deceased member, these services are provided to the surviving spouse or domestic partner or eligible dependent children in those instances where the spouse or domestic partner 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.

Steps in the Legal Process Provided by Amount Paid by The Fund through the Panel Law Firm Fund Member

Consultation	None

The panel law firm has agreed to provide legal representation in these matters with a 25% reduction in its hourly rate, which, for 2022 is $450.00 (This is $337.50 for 2022, but subject to change for subsequent years).

or

How to Obtain the Benefit.... To obtain the Estates and 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.

GENERAL EXCLUSIONS FROM ALL BENEFITS OF THE LEGAL SERVICES PLAN

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 Plan of Benefits.

However, in order to guide the member in his/her utilization of the Legal Services Program 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 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 tax;

- 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 the member was previously represented by an attorney;

- Any legal expenses incurred for a matter which commenced before the member became eligible to receive a benefit under the Plan;

- Any controversy, dispute, proceeding or matter that cannot be litigated or otherwise handled within New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess, Orange and Ulster counties in New York and Bergen, Essex, Union, Hudson, Middlesex, Passaic, Morris, Somerset, Mercer, Sussex, Warren and Hunterdon counties in New Jersey;

- Any controversy, dispute, proceeding or matter which involves a member's business, commercial interest or investment matters;

- The Fund will not cover non-members (e.g. spouse, domestic partners, parents, parents-in-law, etc.) on a first time basis or subsequent to coverage for a prior matter, without the express written consent of the member.

THE FUND WILL NOT PAY:

- 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;

- 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 WITH REGARD TO COVERAGE, BENEFITS OR EXCLUSIONS, PLEASE CONTACT THE FUND OFFICE.