UNITED COLLEGE EMPLOYEES OF FASHION INSTITUTE OF TECHNOLOGY WELFARE TRUST FUND

BENEFIT BOOKLET

January 2016

PART-TIME MEMBERS' BENEFITS

WELFARE TRUST FUND

United College Employees
Of
Fashion Institute of Technology
Welfare Trust Fund

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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)

Dental Benefits:

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

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

Optical Reimbursement Benefits:

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

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

Part time Employees with a Certificate of Continuous Employment (hereinafter may be referred to as a CCE Part time employee) 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") are CCE Part time 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 a CCE Part-time employment status. For details on CCE requirements please refer to the UCEofFIT Collective Bargaining Agreement, Clause 19.1 for Part time Classroom, Part time Non Classroom Faculty and Part Time Classroom Assistants. Please refer to the UCEofFIT Collective Bargaining Agreement Clause 20.6.3 for Part time Staff. A contribution of $100 per semester is required by payroll deductions of $10 twice monthly which discontinues after a $100 contribution per semester has been met.

B. Dependents

The dependents of eligible members as defined below are eligible for those benefits for which a part-time member is eligible.

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:

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 producing documentation stating that you are both living in the same household.

3. ***Children defined as follows:***

Unmarried dependent children through age 26 years, are your natural, legally adopted children (and while in the waiting period) or any child who permanently resides in the member's household 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. Unmarried dependent children over age 19 but less than age 26 (to the end of the month they turn 26) are also eligible for Fund benefits.

Stepchildren may be eligible for benefits provided that 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. For this coverage, an affidavit of dependency must be filed with the Fund, which can be requested from the Fund office.

*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

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 with the Fund office 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 Card deleting 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, you currently contribute $200per year ($10.00 per pay period). This rate is subject to change at any time by the Board of Trustees.

WHEN DOES COVERAGE BEGIN

Your coverage for benefits can begin when you enroll in the Fund. You are eligible to enroll when you receive your CCE. Current CCE employees who are not members of the Fund may enroll during open enrollment periods *(the month of September for an October 1st start date and the month of February for a March 1st start date.)*

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. For physically or mentally disabled, dependent children over 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 through the UCE website at www.uce-fit.org , or by calling (212) 217-3370 or visiting the Fund Office (B902) or by calling the Fund's Third Party Administrator Seneca Consulting Group at 1-866-487-4157**.**

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. However, 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.

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.

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.

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 member 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. located at111 Smithtown Bypass, Suite 112, Hauppauge, NY 11788, 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 someone 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**

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;**
4. Your spouse becomes or domestic partner enrolled in Medicare (Part A, Part B, or both); or
5. **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 18 month 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.

If 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 ($200.00) 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 CCE Part-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 $200.00 directly to the Fund for the entire period of the authorized unpaid leave.

HEALTH CARE PLAN

Coverage

There are two HIP plans: an HMO plan where medical services are delivered at in-network facilities and by participating plan providers, and a Point of Service (POS) plan which allows enrollees to utilize in-network services as well as non-participating providers. The plan covers a comprehensive range of medical expenses including major medical, hospitalization and prescription drugs. There is also an Aetna HMO plan sponsored by FIT through the Human Resource Department.

The current policy year for the HIP is from July 1st through June 31st. Published plan premiums are guaranteed for this time period. During the policy renewal of July 1st, HIP may increase premiums that will then become the responsibility of the participating member.

Enrollment Criteria

All part-time employees are eligible to participate. Enrollment is in the entire month of September for an October 1st start date and the month of February for a March 1st start date. However, if coverage is discontinued, there is a one (1) year waiting period to re-enroll in the plan. New employees may enroll within 60 days of employment.

HOW TO ENROLL

You must complete a HIP 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 deleting your spouse or domestic partner. When enrolling dependents, you must attach to the Fund Enrollment Form or Change of Address, Marital Status, and Dependent Form 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).

Payment

Premiums are required to be prepaid on a quarterly basis or upon initial enrollment if prior to June 30th or December 31st.

HIP PREMIUM PAYMENT SCHEDULE

Premium payments must be received by the date indicated below in order to insure that your health insurance coverage continues uninterrupted. It is your RESPONSIBILITY TO submit payment prior to the date indicated, in enough time for timely receipt by the Fund's Administrator, The Seneca Group. This applies whether or not you receive a bill! It is your responsibility to notify The Seneca Group of any change in your mailing address, TIMELY. The Seneca Group will not guarantee delivery or bills or notices that fail to reach you due to address change, the US Postal Service, or mail stoppage/ forwarding due to vacation.

Coverage period	Premium due date
January 1st through March 31st	**January 1st**
April 1st through June 30th	**April 1st**
July 1st through September 30th	**July 1st**
October 1st through December 31st	**October 1st**

Prescription Drug Plan offered through HIP:

For prescriptions written by a licensed medical provider:

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

	Retail (Up to 30 day supply)	Mail Service (Up to 90 day supply)
Generic	$10	$5
Brand	$20	$10

- No annual or lifetime maximums
- Mandatory generic requirement
- I.D. Card provided

College Premium Reimbursement

Reimbursement from the College and/or Welfare Fund is distributed in June and December to employees meeting eligibility criteria as follows:

Part Time Classroom Faculty

Employed prior to June 1, 1997 Current part-time classroom faculty teaching in the day only, shall receive reimbursement of health insurance costs at twenty-five (25%) per three (3) hour course, prorated.

Current part-time classroom faculty teaching in the evening and/or weekend only, shall receive reimbursement of health insurance costs at five and eight tenths percent (5.8%) per hour, with a six (6) hour minimum teaching load, prorated.

Current part-time classroom faculty teaching a combined day/evening and/or weekend program with six (6) hour minimum, shall receive reimbursement of health insurance costs at twenty-five percent (25%) per three (3) hour course, prorated.

Part time Staff, Non-Classroom Faculty & Classroom Assistants

Employed on or after June 1, 1997 and after a 3 year waiting period
There shall be a three (3) year waiting period before reimbursement of health insurance commences and reimbursement will only be given to those part-time classroom faculty who teach a minimum of six (6) hours per day, evening and/or weekend, or a combined program.

For those part-time classroom faculty teaching only day hours or a combined program, there shall be a twenty percent (20%) reimbursement rate per each three (3) hours, prorated. For part-time classroom faculty teaching evening and/or weekend hours only, there shall be a fifteen (15%) reimbursement rate per each three (3) hours, prorated, but only when teaching six (6) hours or more.

UCE OF FIT WELFARE TRUST FUND REIMBURSEMENT OF HEALTH INSURANCE PREMIUMS
FACULTY

Eligibility criteria includes a Certificate of Continuous Employment (CCE) and teaching at least 6 hours during the appropriate semester. Reimbursement is based on the amount of premium remaining after the College's payment is applied and is computed as follows:

If continuously enrolled in the Health Care Plan **prior to July 1, 1991** and meeting the above eligibility criteria, may receive up to a maximum of $800 per semi-annual period.

If continuously enrolled on or after **July 1, 1991** and meeting the above eligibility criteria, may receive up to a maximum of $400 per semi-annual period based on the premium for an individual plan only.

Additionally, all participants in the Health Care Plan must not be covered by any other primary health care insurance provided through another source.

Non –Classroom Faculty, Staff & Classroom Assistants

Employed prior to June 1st 1997

Health Insurance reimbursement for part-time staff, part-time non-classroom faculty and part-time classroom assistants employed prior to June 1, 1997 for four (4) consecutive years shall be a prorated amount of the individual premium based on the employee's weekly work load. Employees must be working a minimum of one-half of full-time load.

Employed on or after December 1, 1996

Health insurance reimbursement for part-time staff, part-time non-classroom faculty, and part-time classroom assistants employed on or after June 1st 1997, and working eighteen (18) or more hours per week will be paid at thirty-five percent (35%) for six (6) and seven (7) years of employment, fifty-percent (50%) for years (8) through twelve (12), and sixty-five percent (65%) thereafter

If continuously enrolled in the Health Care Plan prior to **July 1, 1996** and meeting the above eligibility criteria, may receive up to a maximum of $800 per semi-annual period based on the premium for an individual plan only.

If continuously enrolled on or after **July 1, 1996** and meeting the above eligibility criteria, may receive up to a maximum of $400 per semi-annual period based on the premium for an individual plan only.

Please note: all participants in the Health Care Plan must not be covered by any primary health care insurance provided through another source.

UCE of FIT Welfare Trust Fund Premium reimbursements are calculated after receipt of College reimbursements.

If the premium reimbursements are delayed for any reason, it is still the responsibility of the member to pay the required premium based on the schedule above.

HEARING AID COVERAGE

Part – time employees with a CCE, who make timely employee contributions to the Welfare Fund, and their spouses/domestic partners/dependents are eligible to utilize this benefit once every 5 years.

Non-Participating Providers:
The fund will pay up to $500.00 towards the purchase of a hearing aid device.

Procedure

1. The need for a hearing aid must be prescribed by a physician or audiologist.
2. Member must return to the Fund office, or it Third Party Administrator, a completed hearing aid reimbursement claim from with a copy of the receipt for the hearing aid. Claim forms may be obtained at the fund office, Third Party Administrator, or through the Welfare Fund's Web site: www.uce-fit.org.

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DENTAL

Eligibility and Coverage

All employees who have a Certificate of Continuous Employment (CCE), and who make timely employee contributions to the Welfare Fund, may receive reimbursement for up to $3,000 per family in a calendar year after satisfying a $50 calendar year deductible,(effective January 1, 2013 the annual deductible is waived for diagnostic and preventative services) in accordance with the plans schedule of benefits.

The following are available in the Fund office:
Dental claim forms (Also available through the UCE Web Site www.uce-fit.org under the Welfare Trust Fund tab)
Dental schedule, which includes:

> Deductible, how to file a claim, extension of benefits, coordination of benefits, general limitations participating dental program, covered expenses, pre-treatment review, alternate benefits provision, expenses not covered and schedule of benefits.

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, the UCE-FIT.org website under the Welfare Trust Fund tab and the S.I.D.S. website at www.asonet.com. Dental 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. 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. a surgical implant of any type.
7. dental services that do not meet common dental standards.
8. services not included as Covered Dental Expenses in the UCE of FIT Welfare Trust Fund Dental Schedule.
9. 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.

LEGAL SERVICE PLAN

This plan is available at no cost to employees who have received a Certificate of Continuous Employment (C.C.E.) and are active members of the Welfare Fund. Benefits are provided by the law firm of Mirkin & Gordon, P.C located at 98 Cutter Mill Road, Great Neck, New York. To receive all services provided by the panel law firm, you will need to contact the Fund Office at 212-217-7986 to make an appointment, or you may call the law firm directly (516) 466- 6030 if you have any questions.

Benefits provided on an annual basis include:

SIMPLE WILL- entitling covered member, his/her spouse/domestic partner, parent(s) and parent(s) in-law to each have a simple will prepared and executed (Once per year) (No Charge)

GENERAL CONSULTATION BENEFIT- entitling covered member to consult an attorney and seek his professional advice concerning any legal problem whatsoever (no Charge)

LIVING WILL / HEALTH CARE PROXY BENEFIT- entitling the covered member, his/her spouse/domestic partner, his/her parent(s) and /or parent (s) in-law for the preparation and execution of a living will and/or health care proxy.

DEED TRANSFER BENEFIT: entitling the covered member who owns a private dwelling, a condominium or cooperative apartment as primary residence and is the process of transferring ownership of such a primary residence to the preparation of the appropriate deed and accompanying documents and affidavits to transfer ownership of the primary residence. (Consultation-No Charge, Negotiation, advice and representation in the transfer by deed $60.00)

PLANNING FOR THE ELDERLY- entitling any covered member his/her spouse/domestic partner, his/her parent(s) and /or parent (s) in-law, the opportunity to consult with any attorney on matters involving placement of elderly family members in nursing homes, available Medicare entitlements and health planning for the elderly, including preparation of powers of attorney[1]. (No Charge)

ESTATE PROBATE AND ADMINISTRATION BENEFIT- entitling any covered member or eligible dependent to all legal services required in connection with the handling of an estate from its inception (probate of will or Petition for Letters of Administration). (Consultation- none, small estate proceedings- $150, $250.00 plus 3% of gross estate up to $500,000.00 and 2.5% of gross estate over $500,000.00 or 25% reduction in usual hourly rate, at the option of the member)

[1] After consulting with the Plan attorney pursuant to this benefit, and it is determined that Elder Law specialist is required, the member shall have access to such specialist. However, fees and charges for same are not covered under this plan.

PERSONAL INJURY (NEGLIGENCE) BENEFIT – entitling the covered member, as well as all members of his/her family to legal representation in connection with the prosecution of a claim for personal injuries suffered as consequence of negligence in those cases which legal counsel believes are worthy of prosecution. The individual will be represented on the basis of a contingent fee of 33 1/3 % of the net sum recovered.

ESTATE PLANNING / TRUSTS BENEFIT- entitling the covered members and their spouses/domestic partners, parent(s) and/or parent(s) in-law with the opportunity to have estate planning trust prepared and executed under the supervision of an attorney from the panel law firm (Consultation $150.00; 20% off usual customary fee of $2,500 per trust for all trusts except QRPT trusts, the fee for which is $3,000 per trust. Fees may change from year to year)

Court costs and disbursements will be the responsibility of the member.

ELIGIBILITY CRITERIA FOR OPTICAL AND HEARING AID PLANS

Classroom Faculty: Certificate of Continuous Employment (CCE) and teaching at least 6 hours, combined day and evening, per fall and spring semester, and contribution to the Welfare Fund.

Non Classroom faculty, staff and classroom assistants: completion of 4 consecutive years of service and working at least one-half the full-time workload.

This summary of benefits is not a substitute for insurance policies/contracts. If there is a difference between this summary of benefit and the insurance policies/contracts, the insurance policies/contracts will rule.

OPTICAL REMBURSEMENT PLAN

The Fund's optical reimbursement plan is administered by its Third Party Administrator, Seneca Consulting Group, Inc. located at 111 Smithtown Bypass, Suite 112, Hauppauge, NY, 11788, tel. (1-866) 487-4157.

Who is Covered

You and your eligible dependents, as defined in the "General Information" Section 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 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
- 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 you may call Seneca Consulting Group at (866) 487-4157, or visit the UCE of FIT 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 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 12 months from the date of service will not be reimbursed.

Exclusions:

1. Non-prescription sunglasses.

2. Services provided by a member of 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's Third Party Administrator, Seneca Consulting Group, Inc. located at 111 Smithtown Bypass, Suite 112 , Hauppauge, NY 11788, tel. (1-866) 487-4157.

Who is Covered

You and your eligible dependents, as defined in the "General Information" Section 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 benefit claim form from the Fund Office, B902 or you may call Seneca Consulting Group at (866) 487-4157, or visit the UCE of FIT 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 12 months from the date of service. Claims filed later than 12 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.

HEALTH ADVOCATE PROGRAM

The UCE of FIT Welfare Trust Fund has retained the services of Health Advocate, Inc., effective November 1, 2007, 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, CCE part-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.