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I. GENERAL INFORMATION

ELIGIBILITY UNDER THE PLAN

You are eligible for benefits under the Sergeants Benevolent Association Health & Welfare Plan (“the Fund or the Plan”):

- You are a current Sergeants Benevolent Association member, OR
- You are promoted and become an active member of the Sergeants Benevolent Association of the Police Department of New York City; AND
- The City of New York provides contributions on your behalf to the Fund.

PARTICIPANTS COVERED UNDER THE PLAN

- You (the current SBA member).
- Your Spouse (See Eligible Dependents).
- Your dependent children up to age 19 (unmarried), up to age 23 (unmarried) if they are full-time students at accredited educational institutions, and up to age 26 for prescription coverage only (See Eligible Dependents).
- Unmarried physically or mentally handicapped children (See Eligible Dependents).
- Registered and currently eligible domestic partners.*

*Note: A ‘domestic partner’ as defined under law means a person, eighteen years (18) of age or older, who is not married or related biologically to the employee or retiree in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with the employee or retiree, who lives with the employee or retiree and has been living with them on a continuous basis, and who, together with the employee or retiree has registered with the New York City Clerk or a New York State County Clerk as a domestic partner of the employee or retiree and has not terminated the domestic partnership. This shall include any domestic partnership registered pursuant to the law and persons who are members of a marriage that is not recognized by the State of New York, domestic partnership, or civil union, lawfully entered into in another jurisdiction. Employees can obtain details concerning eligibility, enrollment, and tax consequences from the agency payroll or personnel office or from the Office of Labor Relations, Domestic Partnership Liaison Unit at (212) 306-7605.

Death of a Participant. Upon a participant’s active non-line of duty death, that participant’s benefits will continue for the spouses and dependent children at no out-of-pocket cost. This benefit terminates when there is a change in social status. This benefit is funded by the SBA Widows and Children’s Fund.

LOSING ELIGIBILITY AND REINSTATEMENT

If a participant becomes ineligible for benefits for any reason under the Plan during the plan year and then subsequently becomes reinstated and eligible for benefits under the Plan at a later date, that participant
will continue to receive benefits at the same level the participant was receiving benefits as of the day the participant became ineligible.

ELIGIBLE DEPENDENTS

Your Spouse – The person to whom you are legally married to at the time an application for benefits is submitted. Spouses are no longer eligible if they are divorced from the member. In order to be eligible for coverage, the Plan requires presentation of a valid court or clerk certified marriage certificate.

Your children – Your children up to age 19 (unmarried), up to age 23 (unmarried) if they are full-time students at accredited educational institutions, and up to age 26 for prescription coverage only (Young Adult Prescription Coverage To Age 26) and who are enrolled by you with the Fund as your dependent. Your eligible children include:

- **Stepchildren** are the legal biological son or daughter of your spouse (proven by a valid birth certificate). If the stepchild is eligible for benefits under both the legal natural mother and legal natural father, that stepchild is not eligible for benefits under the Plan. In order to be eligible for coverage, the Plan requires the presentation of a valid legal marriage certificate to the stepchild’s natural parent, as well as a valid legal birth certificate for the stepchild and a completed “Statement of Dependency Form” (provided by the Fund Office upon request). In the event that your spouse is not named on the child’s birth certificate, you must also provide a court or clerk certified declaration of paternity for the parents in addition to the items mentioned above. Upon your divorce from the stepchild’s legal biological mother or father, the stepchild will no longer be covered under the Plan.

- **Legally adopted children** (including those who have been placed with you for adoption provided you have commenced legal adoption proceedings and proof such proceedings have been provided to the Fund Office) provided you have assumed legal responsibility for their support leading up to the adoption becoming final. In order to be eligible for coverage, the Plan requires the presentation of a valid court or clerk certified legal adoption certificate or proof of the legal adoption proceedings and a completed “Statement of Dependency Form” (provided by the Fund Office upon request).

- **Full-time students** are eligible for coverage up to their 23rd birthday if they are enrolled full-time in an accredited educational institution and proof of such status is provided to the Fund Office on the "Dependent Student Certification Form. A Dependent Student Certification Form is required for each new semester and must be submitted to the Fund Office within one month of the start of each semester. Participants are obligated to notify the Fund Office with all changes in student status. If your child reaches age nineteen (19) during a school vacation period, coverage will continue, as long as the child is enrolled full-time in an accredited education institution. You must provide written notification to the Fund Office that the child plans to resume classes on a full-time basis at the end of the vacation period, and subsequently completes Dependent Student Certification Form within one month of the start of the next succeeding semester.

**Note:** The Plan will provide up to one (1) year of extended coverage to dependent children enrolled full-time at an accredited education institution who would otherwise lose health coverage when they take a necessary medical leave of absence for a serious illness or injury. This extended coverage also applies when the medical necessity results in a change in enrollment by the student, such as full-time to part-time enrollment that would otherwise cause the child to lose student status under the terms of the Plan. The child must have been enrolled in the group health plan as a full-time student at an accredited education institution immediately before the first day of leave of absence. The child’s leave of absence must be medically necessary, commenced while the
child is suffering from a serious illness or injury, and has caused the child to lose coverage under the Plan. The Fund Office must receive a written certification by the child’s treating physician stating that the child is suffering from a serious illness or injury, and the leave or change of enrollment is medically necessary. At the end of the year of medical leave, dependents who return to school as full-time students may continue coverage under the terms of the Plan, but coverage may be terminated for dependents who do not return to school.

- **Young Adult Prescription Coverage To Age 26**: Your child is eligible for the Young Adult Prescription Coverage To Age 26 benefit only if they are not eligible for an employment-based prescription plan. In order to enroll your child you MUST fill out the “Young Adult Prescription Coverage To Age 26 Form” (provided by the Fund Office upon request) and submit it to the Fund Office annually during the enrollment period of October 15 – November 15.

- **Unmarried, physically or mentally handicapped children** who become totally disabled while covered by the Fund and before reaching the age limits above, remain disabled, are unable to work, who reside in your home, and are wholly financially dependent on you for support. To continue coverage for these children beyond age nineteen (19) or twenty-three (23), you must provide proof of the disability by submitting the City Health Plan’s Disability Determination to the Fund Office within thirty one (31) days after your child’s coverage would normally end. A child who becomes qualified for Medicaid coverage will no longer be eligible for benefits under the Plan. You may also be asked by the Fund Office to update this proof from time-to-time.

Eligible dependents do not include foster care children, the children of domestic partners or guardianship (unless in the process of legal adoption).

### NOTIFICATION OF YOUR SOCIAL/FAMILY STATUS

It is important that you immediately notify the Fund Office of any change in your social/family status (adding dependents due to marriage, domestic partnership, birth, or adoption of a child, or dropping dependents due to death, divorce, legal separation, termination of domestic partnership or a child reaching an ineligible age or losing full-time student status).

If it is found that a participant or beneficiary fails to submit the requested information on the Statement of Dependency, fails to notify the Fund Office immediately following a change in that participant or beneficiary’s social/family status, change in student status, makes a false statement, or furnishes fraudulent or incorrect information, the authorized representatives of the Fund Office, Trustees, or any of their designees in their sole and absolute discretion reserve the full authority to deny, suspend or discontinue the participant or beneficiary’s benefits provided under the plan at any time and for any length of time. Furthermore, a failure to notify the Fund Office of a change in social/family status will leave the participant or beneficiary personally responsible for all expenses/costs incurred by the Fund, retroactive to the effective date of the assigned coverage whereby the dependent was ineligible for benefit coverage under the Plan, as a result of administering benefits to members and dependents in this fraudulent situation.

Any participant or beneficiary who willfully and knowingly engages in an activity intended to defraud the Plan will face loss of coverage under the Plan, will be held personally liable to the Fund for all costs/expenses incurred by the Fund, and will be subject to all other legal remedies available to the Fund at that time.

**Keep the Plan Informed of Changes.** In order to protect yours and your family’s rights, it is imperative that all participants and beneficiaries keep the Fund Office up-to-date of their current family/social status,
address, telephone number, and e-mail address. You should also keep a copy, for your records, of any notices or correspondence you send to the Fund Office.

Please reference Section XV, “Failure to Disclose” for additional information.

ADMINISTERING BENEFITS

In the interest of protecting Fund participants, the Fund Office no longer uses participants’ social security numbers for identification purposes and instead electronically converts all benefit programs to an alternate identification number: the member’s 6-digit tax number.
II. PRESCRIPTION DRUG BENEFITS

ACTIVE MEMBERS’ PRESCRIPTION DRUG BENEFITS

The SBA prescription benefits program has teamed up with True Health Benefits and OptumRx to assist you with your prescription needs and help you to save money in the process. If you have any questions, you may contact the OptumRx customer service center at (877) 559-2955 or the Fund Office.

Eligibility

All Active members and their dependents that are eligible to participate in this Plan, as highlighted in Section I, “General Information”, are entitled to this benefit.

Prescription Drug Card Program

This is a self-insured benefit provided by the Fund. Every covered member is issued a prescription drug card that will certify the member and dependents eligibility for participation in the prescription drug program. The Fund pays up to $7,500 per fiscal year (July 1 to June 30) for all Active family covered prescription drug expenses incurred for illness, injury, or disease.

Pharmacy Network

You have access to an extensive national pharmacy network comprised of more than 56,000 independent and chain retail pharmacies. Please visit the OptumRx Web site at www.OptumRx.com to use the pharmacy finder feature to find the pharmacy nearest to you. Simply input your ZIP code and you will receive a list of participating pharmacies along with their locations and phone numbers. You may also click on the map icon to view directions to the pharmacy.

Using Your Prescription Card

You must present your OptumRx/True Health Benefits prescription benefit card at any participating pharmacy. The participating pharmacy will electronically process your claim and collect the applicable co-payment.

If you use a non participating provider or fail to present your OptumRx/True Health Benefits prescription benefit card to the retail Pharmacist, when making a qualified drug purchase, you will be responsible to pay the pharmacy 100% of the non discounted cost for your medications. Members may then submit an eligible claim, for reimbursement, by preparing an “OptumRx Prescription Reimbursement Form” and forwarding the paper claim direct to OptumRx. All S.B.A. pharmacy discounts and required co-pays will apply.

Mail Order Service

Maintenance medications are available through our mail service pharmacy OptumRx RX. For registration, order forms, or information on covered medications please contact OptumRx RX at (877) 390-9200 or the Fund Office.

Mandatory Generic Drug Program

The SBA Prescription Drug plan is a mandatory generic reimbursement program. Under the mandatory generic program, when there is a generic equivalent available, the Fund will cover the total cost of that generic equivalent. Should you or your doctor insist on receiving a brand name medication where a
generic equivalent is available, you will be responsible for the full cost of the brand name medication. You will not be reimbursed by the Fund. As this can be very costly to you, we recommend that you thoroughly discuss generic medications with your physician.

**SBA Prescription Program Co-Pays**

There is a 10% member co-payment coupled with the Fund paying 90% of the cost of each brand name dispensed prescription drug. All generic prescriptions are covered at 100% by the Fund, meaning there is no out-of-pocket expense to participants for generic drugs.

**Catastrophic Prescription Benefit**

This benefit provides coverage for active participants who have exceeded the Funds’ allowable prescription benefit limit of $7,500 per family unit. Once a participant has reached the Funds’ prescription benefit limit of $7,500, the participants will then be responsible for the next $1,500 out-of-pocket costs of covered prescription drugs purchased using the prescription benefit card. Once the participant has exceeded the $1,500 out-of-pocket costs, the Fund will then provide a benefit of covering 100% prescription drug coverage up to a maximum of $20,000 limit covered by the Fund.

The following restrictions apply to the catastrophic prescription coverage:

1. The participant must use his or her prescription card for all claims;
2. All recommendations by Wise Choice Rx must be adhered to;
3. There will be no coverage or accumulation toward the benefit limit for prescriptions resulting from an injury or illness sustained in the line of duty, since these prescriptions are now provided by the City of New York; and
4. The participant must disclose any other available prescription coverage.
5. If it has been determined that there are cost savings to be realized by the Fund or the participant outside of retail for prescription services such as, mail order or specialty pharmacy, the participant is obligated to comply with the Funds’ determination.

**Covered Drugs**

Covered drugs must be prescribed by a doctor, dentist or physician licensed in the state in which the treatment is given for illness, injury or disease, and must be dispensed by a licensed pharmacist.

**Coverage of Diabetes Management**

Under New York State law, insurance companies are mandated to cover diabetes related drugs for Non-Medicare participants. These medications are covered under the basic medical benefits by all New York City health plans. Diabetes management education is also provided to educate members on the proper self-management of their condition. Members requiring diabetes products should bring their medical benefits ID card to their pharmacy along with their prescriptions. Those members that are enrolled in Medicare, or have eligible dependents enrolled in Medicare, should contact the Fund Office so arrangements may be made for them to obtain their diabetic medications through the SBA Prescription Plan.

**Plan Coverage of “Statin” Class Medications**

All participants presenting a new or existing prescription for brand name Statin class medications are subject to a step therapy program or must have an approved prior authorization form on file with OptumRx. This step therapy program necessitates participants initially utilizing first line generic Statins. The participant co-pay for all generic statin class medications is waived. The following generic
medications are eligible under this program Aporvastatin (generic of Lipitor), Lovastatin (generic of Mevacor), Pravastatin (generic of Pravachol) and Simvastatin (generic of Zocor).

**Line of Duty Medications**

The City of New York Police Department is responsible for all active line of duty medications. At this time active members and the Fund will no longer have to absorb the cost for short and long term pharmaceutical drugs related to new and old line of duty conditions or injuries. This change positively affects all active SBA members but is especially relevant to those who were active members on September 11, 2001 and during its aftermath. Members, who worked on or near the World Trade Center site or at the Fresh Kills Landfill, run a far greater risk of incurring various ailments in the years ahead.

**Birth Control Coverage**

All generic birth control pills are covered by the Fund with a zero dollar co-pay. In addition, brand name birth control pills along with related products such as patches, self-insertible devices and emergency contraceptives are available with a 100% co-pay. This entitles participants who choose to use brand products availability of a discount of 17 to 25% off the retail prices.

**Baby Formula Coverage**

The Fund covers reimbursement for participants’ out-of-pocket costs for prescription specialty baby formula above the usual and customary cost normally experienced by the participants, including only Elecare, Neocate, Nutramigen LI PIL, Nutramigen AA LI PIL, and Phenyl-Free 2 HP. Members require a prescription from a licensed medical provider, a letter of necessity and eligible formulas must not be readily available as an over the counter (OTC) product.

**Coverage for Medicare Qualified Dependents**

The Fund’s individual maximum allowable benefit for Medicare Part D participants is $7,500.

**PICA Prescription Plan**

The PICA prescription drug plan is a negotiated health benefit gained through collective bargaining between the Municipal Labor Committee and the City of New York. Effective July 1, 2005 PICA covers drugs that are injected and cancer drugs only. Use your PICA prescription benefit card to obtain these drugs. They are not covered by the Fund prescription drug plan. To obtain more information regarding PICA, you can call Express Scripts Customer Services at (800) 467-2006 or visit www.express-scripts.com. **Members or dependents who are Medicare qualified are not eligible for PICA drugs.**

**What is Not Covered by the Prescription Drug Plan**

- Drugs that are not federal legend drugs. These are drugs, which may be purchased without a prescription and are not covered, except as noted;
- Allergens, antigens, and other prescription drugs purchased from a laboratory or physician directly;
- Fertility Drugs;
- Growth Hormones;
- Impotence Drugs; and
- Any prescription prescribed for reasons other than illness or disease.

**Customer Service**
OptumRx has dedicated customer service representatives available to serve you 24 hours a day, 7 days a week. You may reach OptumRx toll-free at (877) 559-2955. The Fund Office is also available to answer questions or assist members.

**Prior Authorizations**

OptumRx’s physicians and pharmacists, who serve on the Pharmacy & Therapeutics (P&T) Committee, along with physician or pharmacist representatives of True Health Benefits, are responsible for reviewing all new medications as they come to market. With each agent, they consider whether a medication should be covered under the prescription benefit. In addition, they may recommend quantity limits and prior authorization to ensure appropriate use. When making a recommendation, the P&T Committee focuses on the medication's overall health benefit as well as the cost. The P&T Committee will consider FDA recommendations, manufacturer package labeling instructions, and published clinical recommendations, such as the Journal of the American Medical Association (JAMA).

Based on the P&T committee decisions certain medications have prior authorization guidelines established. Members can request prior authorization, where necessary, by contacting the OptumRx customer service center toll-free at (877) 559-2955. A member service representative can prepare and fax a prior authorization form to the prescribing physician. When the physician returns the completed form to OptumRx, a clinical review of the documented information is completed within two business days. The clinical decision is documented in writing to the physician. A copy of the letter provided to the physician is also provided to the member.

**Quantity Limits**

Quantity limits are based upon FDA guidelines, published clinical recommendations, such as the Journal of the American Medical Association (JAMA), as well as FDA approved labeling as described in the manufacturer package insert. Limits are intended to encourage appropriate dosing. These limits are not intended to restrict access to quantities of medications where limits would not be considered functional or appropriate. If you have questions regarding these limits, please contact the Fund Office or the OptumRx Customer Service Center (877) 559-2955.

**Some Frequently Asked Questions**

**How do I get a prescription filled?** Simply present your prescription card and prescription to the pharmacist. The pharmacist will process your claim electronically and collect the applicable co-payment.

**How do I know if a pharmacy is in the network?** To find a participating pharmacy, simply visit the OptumRx Web site at www.OptumRx.com to view the pharmacy finder. Input your ZIP code and you will receive a list of the participating pharmacies along with their locations and phone numbers.

**Who should I call with questions or concerns about the program?** Please call the OptumRx customer service center (877) 559-2955 with questions about your benefits contact the Fund Office.

**Who should I call with questions or concerns about the Mail Order service?** Please call our mail service pharmacy, OptumRx RX at (877) 390-9200, 24-hours a day, 7 days a week, or the Fund Office.

**MONITORING PARTICIPANTS’ PRESCRIPTION DRUG BENEFITS**
The Board of Trustees, and any person or persons it properly designates, including the Fund Office, has the exclusive right, power, and authority, in its discretion to monitor and analyze prescription medication provided to each participant or beneficiary receiving benefits under the Plan.

The Board of Trustees, and any person or persons it designates, including the Fund Office, has the exclusive right, power, and authority, in its discretion to investigate any instances whereby it is suspected that a participant or beneficiary is abusing their prescription drug benefits under the Plan, and in response, with the Trustees approval, take any and all appropriate action thereby denying, suspending or discontinuing that participant or beneficiary’s prescription drug benefits provided under the Plan at any time and for any length of time.

This action in relation to suspected prescription drug abuse is subject to the participant appeal procedure outlined in Section X, “Appeal Procedure”, of this summary plan description.
III. DENTAL BENEFITS

ACTIVE MEMBERS’ DENTAL BENEFITS

The Plan offers a choice of two dental benefit options. You may select one of the following programs for you and your eligible dependents. These choices include:

- Self-Insured, Fee-for-Service Reimbursement In-Network Plan (PPO - Active) / Schedule Reimbursement Out-of-Network Plan; and

- Self-Insured, Comprehensive Managed Care Plan.

Annual Changeover Period

SBA members have the opportunity to change their dental plan election in October of the plan year. The effective date of your dental plan change is January 1 of the following year.

Eligibility

All Active members and their dependents that are eligible to participate in this Plan, as highlighted in Section I, “General Information”, are entitled to this benefit. However, only eligible dependent children up to their 19th birthday are covered for orthodontia benefits.

Reimbursement Plan

There is a Preferred Provider Organization (PPO) and an Out-of-Network component to this Plan. In both programs there is an individual $2,500 maximum allowable annual benefit per participant or beneficiary.

Fee-for-Service Reimbursement In-Network Plan (PPO - Active). You may select any participating Healthplex PPO Active provider. These providers will accept the reimbursement allowances as payment in full. The Plan provides assignment of benefits to your in-network dentist. Upon completion of your dental work, the reimbursement check will be mailed directly to your participating dentist. For a list of Active Preferred Providers contact Healthplex Customer Service at (800) 468-0600 (Press Option 1), www.healthplex.com, or the Fund Office.

Fee-for-Service Schedule Reimbursement Out-of-Network Plan. You may select any duly licensed dentist or specialist whom you and/or your eligible family members prefer. Upon completion of dental services and submission of a required claim form you will be reimbursed according to the schedule of payments for expenses you incur for preventive, basic and major non-orthodontia dental services. You are responsible to your dentist for any costs beyond the schedule of reimbursement. Upon completion of your dental work, the reimbursement check will be mailed directly to you.

For another description for the above Reimbursement plans please refer to the DENTAL ACTIVE REIMBURSEMENT PLAN BROCHURE, and for additional information please contact Healthplex customer service at (800) 468-0600 (Press Option 1), www.healthplex.com, or the Fund Office.

Note: All benefits are governed by the provisions of the master group contract between Healthplex and the Fund.

Submitting a Claim

Claim forms are available through our dental provider, Healthplex, at the Fund Office or on the SBA
website (DENTAL ACTIVE CLAIM FORM). Please read these forms carefully and follow all instructions provided on the form when completing. Forms will be returned if incomplete or incorrect. When you have a claim, you should promptly submit the completed claim form to Healthplex direct. Claims submitted 180 days after completion of dental services will be denied. It may become necessary to submit additional proof or information concerning a particular claim. Healthplex reserves the right to require such proof or information, including but not limited to all of the following:

- Dental chart showing work to be performed before the treatment of submitted claim,
- X-rays, lab or hospital reports,
- Cast molds or other evidence of the dental condition or treatment,
- Post-treatment examination of the patient, at the Fund’s expense, by a dentist it selects.

All claims must be submitted directly to:

Healthplex
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553
T: (800) 468-0600

How Benefits are Affected by the Alternate Benefit Provision

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

In addition to this description, each subscribing participant is provided with a Healthplex brochure explaining in more detail the above provisions and containing the schedule of reimbursement for most frequently performed dental services. This booklet and the applicable Healthplex brochure contain a general description of your dental benefit plan for your use as a convenient reference. All benefits are governed by the provisions of the master group contract between Healthplex and the Fund.

Pre-Authorization

When a dentist’s charge for a proposed course of treatment is $250 or more, a dental service treatment plan must be submitted to Healthplex for approval before treatment is started. X-rays and a description of the procedure must be included with treatment plan being submitted for pre-authorization. The treatment plan, prepared by the dentist, must be submitted direct for review by Healthplex, no later than thirty (30) days after the initial examination. Pre-authorization by Healthplex is limited to the approval of the course of the treatment proposed; it does not include approval of payment for services not covered under the dental plan, nor is it a determination of the patient’s eligibility.

A claim submitted to Healthplex for pre-authorization will be returned to the dentist indicating their decision. Your dentist should contact you upon receipt of the returned form. Approval will include the maximum amount of reimbursement you will receive upon completion of the approved dental services. The dentist may proceed to provide the approved services after you have been notified of the reimbursement amount and agree to have the approved work performed. Healthplex reserves the right to modify or deny payment of claims of $250 or more which have not been approved by Healthplex before treatment begins.

Note: Crowns for Dental Implants – All necessary dental caps/crowns to be used with dental implants are covered by the Fund. The Fund does not cover the cost of the dental implant itself.
Orthodontia Benefits

Eligibility. Orthodontia benefits are available only to eligible dependent children up to the day of the child’s 19th birthday. Effective as of the child’s 19th birthday, all orthodontia benefits for that child cease under the Plan.

Orthodontia Benefits/Expenses for In-Network (PPO - Active)

Benefits shall be provided for eligible dependent children consisting of necessary diagnosis and treatment of Class 2 and 3 malocclusions which cause interference with normal functions. The treatment plan, with requires X-Rays and molds, must be approved by Healthplex before treatment is started. Active members will not incur any out of pocket expenses for covered procedures (appliances are not covered), provided you select one of the orthodontists participating in the Preferred Provider Organization Panel (PPO - Active).

The PPO orthodontics benefit consists of 24 months of active treatments at $90 per month with a $750 initial cost for work-up, diagnosis, and insertion of appliance. This benefit is up to a lifetime maximum of $2910 per eligible dependent child. The orthodontics benefit is not included in the aforementioned maximum allowable annual benefit.

The orthodontics benefit requires multiple treatments over a 24-month period. If a dependent becomes newly eligible for benefits under the plan and is currently receiving orthodontics treatments or has received orthodontia treatments in the past, then the degree of eligible services under the plan will be prorated based upon the services performed in the past.

If a covered dependent begins orthodontic treatment while you are an active member and you retire prior to the completion of treatment your benefit will revert to the retiree reimbursement fee schedule. Any post retirement benefit will be prorated based on the cost incurred to the Fund up to the point of retirement. Members who are considering retirement can contact Healthplex to determine the remaining cost, if any, that they may incur.

Orthodontia Benefits/Expenses for Out-of-Network.

Benefits shall be provided for eligible dependent children consisting of necessary diagnosis and treatment of Class 2 and 3 malocclusions which cause interference with normal functions. The treatment plan, with requires X-Rays and molds, must be approved by Healthplex before treatment is started. Orthodontia services are reimbursed according to a fee schedule up to a lifetime maximum of $1,905 per eligible child. The orthodontia benefit payments are not included in the yearly dental maximum.

Covered expenses here include: (1) Initial work up, diagnosis and insertion of appliance are covered once in a lifetime up to $460; and (2) $70 per active monthly treatment with a maximum of twenty (20) consecutive treatments. If your dependent misses a monthly treatment, Healthplex will not reimburse for that month but it will be counted toward the twenty (20) consecutive treatments. Also covered are three (3) passive treatments at $15.00 per treatment. Please note that the Fund does not cover replacement or repair of any lost or damaged orthodontic appliance.

Orthodontia Benefit Exclusion

The Fund does cover any orthodontia related appliances, including but not limited to, bite plates, palate expanders, tongue guards, retainers, and cosmetic braces.

Dental Coverage Exclusions
Charges incurred for the following services will not be paid:

- Treatment from anyone other than a licensed dentist or physician (except routine cleaning of teeth and fluoride application which can be performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician),
- Facings, veneers, or similar material placed on molar crowns or pontics,
- Services performed by a member of your or your spouse’s immediate family, unless acceptable proof of payment is provided for those services,
- Services or supplies that are cosmetic in nature or directed toward a cosmetic end,
- Any service or supplies incurred, installed or delivered before you or your dependent(s) become eligible for benefits from this Fund,
- Replacement of a lost, missing or stolen prosthetic orthodontic appliance,
- A broken appointment,
- Any services received from a medical department, clinic or any facility provided or furnished by your spouse's/domestic partner's employer,
- Any service that is not medically necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist,
- Services or supplies that do not meet accepted standards of dental practice including experimental or investigational services or supplies,
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared,
- Any duplicate prosthetic appliance except as specifically provided,
- Oral hygiene, or dietary instruction or plaque control programs,
- Dental Implants, except the crowns for these dental implants,
- Wiring or bonding teeth or crowns to act as a splint for any reason,
- Injury arising from employment, covered by workers’ compensation,
- Services or supplies for which you are not required to pay,
- Appliances, restorations or any procedure to alter vertical dimension for cosmetic purposes, or
- Services or supplies not specifically listed under covered expenses.

**Comprehensive Managed Care Plan**

Covered services can only be rendered by participating dentists. Each covered person must select one participating dentist, per family, to provide general dental services. These general dentists will provide all covered services according to the schedule of copayments. Most services will be provided at no cost. Others may have small copayments that patients will pay directly to the dentist. When endodontic, periodontal, surgical or orthodontic treatment is needed by a specialist, the participating general dentist will refer the case to participating specialists. In the event that participating specialists are not available within 50 miles of your participating general dentist, you may be entitled to receive a benefit equal to the amount that the Fund would pay a participating specialist. Members have no benefits when treatment is provided by a non-participating general dentist or when specialty services are provided without a referral from Dentcare or the participating general dentist. There is no individual maximum allowable benefit cap for services under Managed Care. Crowns for dental implants are also covered under the Managed Care Plan.

**THE COORDINATION OF DENTAL BENEFITS**

The Plan has a Coordination of Dental Benefits feature, which prevents the duplication of payments when participants or their eligible dependents have coverage under more than one group dental plan. At this time, the Plan does not coordinate benefits for prescription or vision benefits. When you submit claims to
the Plan, you must indicate your other coverage, if applicable. The Plan will then be able to coordinate your benefits with your other coverage.

When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all group plans will not exceed 100% of the total amount charged. If you and your spouse are both participants of the Fund and eligible for benefits, your benefit payments will also be coordinated not to exceed 100% of the total amount charged. Where there is multiple coverage, the plan that is primarily responsible for paying a person’s expenses is the “primary” plan for that person. As primary, it pays benefits first before any other insurer. Plans that pay after the primary plan are “secondary”. Here are the rules for determining when another plan is primary and secondary under this Plan.

- If the other plan does not have a coordination of benefits provision, it is your primary coverage.

- If the other plan has a coordination of benefits provision:
  
  - For you (the current SBA member) – the Plan is considered your primary plan.
  
  - For your spouse or your domestic partner – the plan provided by his or her employer is primary.
  
  - For your eligible dependent children - The “birthday rule” (month and day only) determines which plan (yours or your spouse’s) is primary. The plan covering the spouse whose birthday falls earlier in the year is primary for your eligible dependent children. If you and your spouse have the same birthday, the plan covering you or your spouse the longest is primary.

The Administration of Dental Benefits. Please be on notice that the coordination of dental benefits is administered by the Plan’s dental consultant according to its own procedures and rules.

The Right to Recover. The Plan and the applicable insurance companies have the right to obtain and exchange information about your coverage.

If the Plan makes payment for benefits that is in excess of expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or fraud or for any other reason (including for example, your failure to notify the Fund Office regarding a change in social/family status), the Plan reserves the right to recover such overpayment through whatever means necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

HOW THE COORDINATION OF DENTAL BENEFITS WORKS

If you are a participant or beneficiary covered under the Plan and are eligible for benefits from another group plan:

- Submit your claim to Healthplex.

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

- You will receive any additional benefits which may be due for this claim under the second plan.
• The total amount you receive for the claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged. If your spouse has a claim and is eligible for benefits under another group health and welfare plan:
  o Your spouse must submit a claim to his or her plan first.
  o After the claim is paid by your spouse’s plan, a claim will be paid under this Plan.
  o The total amount paid for the claim from any group plan under which your spouse is eligible and under the Plan cannot exceed 100% of the total amount charged.

If a claim is submitted to the Plan for a child when one parent is a covered participant of the Plan and the other parent is a covered participant of another plan, which is as follows:

**Birthday Rule**

• Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in the calendar year.

• After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.

• The payment you receive for the claim from both plans cannot exceed 100% of the total amount charged.

**Note:** if your spouse’s plan uses the gender rule instead of the birthday rule (month and day only) for coordination of benefits, this plan will follow the gender rule.

• If the claim is submitted for a child whose parents are divorced when one parent is a covered participant of the Fund and the other parent is a covered participant of another plan, which is as follows:

**Gender Rule**

 o If the parent with custody has not remarried:
   ▪ Submit the claim to the plan which covers the parent with custody first and then after the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits from the first plan.

 o If the parent with custody has remarried:
   ▪ Submit the claim to the plan which covers the parent with custody first,
   ▪ Then submit the claim to the plan which covers the stepparent second, and lastly
   ▪ Submit the claim to the plan which covers the parent without custody.

• Notwithstanding the above, if there is a court order which established financial responsibility for the medical, dental or other health care expenses of the child, first submit the claim to the plan covering the parent with the court ordered responsibility. A copy of such court order must be on file with the Fund Office.
IV. OPTICAL BENEFITS

ACTIVE MEMBERS’ OPTICAL BENEFITS

This optical benefit administered by Davis Vision is designed to provide coverage of optical services rendered to members and their eligible dependents by an optometrist or ophthalmologist. This benefit includes an examination, frames and lenses (or contact lenses).

Eligibility

All active members enrolled in the Plan and their eligible dependents are entitled to this benefit.

Extent of Optical Coverage

This optical benefit consist of one (1) complete eye examination, including dilation as professionally indicated, and one (1) pair of eyeglasses or one (1) year supply of contact lenses every twelve (12) months.

Covered Lenses

- Glass Grey #3 Prescription Lenses;
- Oversize Lenses;
- Post Cataract Lenses;
- Fashion, Sun, Gradient Tinted Prescription Plastic Lenses; and
- Polycarbonate Lenses - These lenses are thinner and lighter than traditional plastic lenses and are ten times more impact resistant. These lenses are the standard for safety glasses, sports goggles and children’s eyewear.

Covered Frames

Our Plan offers access to the Davis Vision “Exclusive Collection” of designer frames for eyeglasses. The cost for this premiere frame collection of over 200 name brand frames is covered in full.

- All plan eyeglasses come with a breakage warranty for repair or replacement of the frames and/or lenses for a period of one (1) year from the date of delivery.
- Second and third pairs of eyeglasses are also available at fixed discount prices.

Covered Contact Lenses

In lieu of eyeglasses (frames and lenses) plan participants may select contact lenses from the Plan’s contact lens collection. This contact lens collection features the most popular contact lens brands available. A one (1) year supply of contact lenses is covered in full. The contact lens benefit includes daily wear, planned replacement and disposable lenses.

For further information, please contact the Davis Vision customer service center at (800) 999-5431, visit Davis Vision’s website at www.davisvision.com, or contact the Fund Office.
V. BODY SCAN BENEFIT

ACTIVE MEMBERS’ MEDICAL SCAN BENEFITS

The Fund has worked with Inner Imaging, an affiliate of the Heart Institute at Beth Israel Medical Center, to create a benefit which offers a discounted price for a medical screening exam for SBA active members, spouses and their dependent children.

This discounted cost for the body scan, which includes testing for the heart, the lungs, the abdomen, and the pelvic area, is $375 (ordinarily this body scan is offered at a price of $850). For active members, who are 35 years of age or older, the Fund will subsidize $200 of the $375 body scan cost. Therefore, active members will pay only $175 for this one-time body scan. Members, who schedule a nuclear stress test, at the same time, have the $175 waived by Inner Imaging. For active members’ spouses and dependent children, the Fund offers the body scan for $375. If eligible, active members must call the Fund Office to request a voucher before scheduling your body scan. Spouses and dependents must show the member ID card at the time of service. Please call Inner Imaging at (212) 991-5445 to schedule your appointment and remember to bring your voucher. Please be advised that all quoted rates are subject to change without advance notification.
VI. HEARING AID BENEFIT

THE BENEFIT

For Active Members, Members’ Spouses and Registered Domestic Partners - The Fund offers a $500 stipend per hearing aid device with a maximum benefit of $1000 every four (4) years.

For Eligible Dependent Children - The Fund offers a $1000 stipend per hearing aid device with a maximum benefit of $2000 every two (2) years.

BENEFIT GUIDELINES

1. The device must be prescribed by a board certified Otolaryngologist.
2. The requesting participant must provide a paid itemized bill that reflects the qualified product purchased.
3. The participant must submit a signed letter from their Otolaryngologist on official letterhead outlining the detailed diagnosis and need for hearing aid. Participant must also submit all test results, including all Audiometric tests.
4. The claim must be submitted within one (1) year of the purchase date.
5. All claims are subject to review for duplication, coordination of benefits, worker’s compensation, etc. At no time will the Fund reimburse more than 100% of a claim cost.
6. The benefit does not cover the exam, repairs, batteries, accessories and service contracts.
7. The Fund will reimburse for ear molds, for children only, in lieu of a new device under the same two year guidelines.
8. Please request the required forms from the Fund Office, complete the forms, and promptly return them to the Fund Office.
VII. CATASTROPHIC MEDICAL PLAN

THE CATASTROPHIC BENEFIT

This self-funded benefit offered by the Fund, where the Fund serves as the last payor, was established to assist our members and eligible dependents (who are subscribers of a PPO/indemnity or a POS health plan) within the New York City Employee Health Benefits Program defray some of the covered medical and surgical expenses incurred for services rendered by non-participating or out-of-network providers.

Eligibility

SBA members are eligible for coverage, as well as spouses/domestic partners and dependent children who are covered under a participating provider organization (PPO) or a point-of-service (POS) plan presently being offered by the New York City Employee Health Benefits Program.

Definition of PPO, POS, and HMO/EPO

Participating provider organization (PPO) indemnity plans. These plans offer the option to use either a network provider or an out-of-network provider for medical and hospital care. PPO plans contract with health care providers who agree to accept a negotiated payment from the health plan and predetermined co-payments from subscribers as payment in full for a schedule of medical services provided. When the subscriber uses a non-participating provider, the subscriber is subject to deductibles and/or a lower provider reimbursement schedule. GHI/CBP is an example of a PPO.

Point-of-service (POS) plans. These plans offer the freedom to use either a network provider or an out-of-network provider for medical and hospital care. If the subscriber uses a network provider, health care delivery resembles that of a traditional HMO, with prepaid comprehensive coverage and little out-of-pocket costs for services. When the subscriber uses an out-of-network provider, health care delivery resembles that of an indemnity insurance product, with less comprehensive coverage and subject to deductibles and coinsurance.

Health Maintenance Organization (HMO) / Exclusive Participating Organization (EPO). The Fund’s catastrophic coverage plan does not cover subscribers of EPOs or HMOs as they do not allow for any out-of-network coverage.

The Catastrophic Coverage Benefit

The benefit pays up to 100% of reasonable and customary eligible expenses after a $2,000 out-of-pocket annual deductible per person has been reached. Eligible out-of-pocket expenses are those medical and hospital charges that are considered reasonable and customary by the Plan and are not fully reimbursed by an eligible City Health Plan.

For the purposes of the catastrophic benefit, “annual” means the twelve-month period commencing as of the date the qualified service was provided to the participant. Additionally, the participant must complete and submit a catastrophic benefit claim form to the Fund Office within twelve-months of the exact date of the participant’s date of service. For additional information please contact the Fund Office.

Benefit Limits and Maximums

There is a lifetime maximum benefit of $250,000 per covered person. Within this lifetime maximum benefit are the following: Required and approved by your insurance carrier only PPO private duty
nursing is covered, after the participant has exhausted all of his or her benefits, in full for the first unpaid $25,000 and then at 50% for the remainder up to a lifetime maximum of $50,000.

**Services or Charges Not Covered by the Catastrophic Benefit**

In addition to the benefit exclusions of the Fund, the catastrophic benefit does not cover the reimbursement of co-pays, deductible, penalties, late fees, related taxes, prescription drugs, workers compensation benefit claims, occupational injury, all fertilization related treatment and procedures, no fault auto insurance medical expenses, auto accidents, experimental procedures, any medical, surgical or hospital service/charge not approved for payment by a Member’s Participating Provider Organization (PPO) or Point of Service Plan (POS). Services rendered by non-participating PPO providers or out-of-network POS providers must be approved by the member’s health plan.

**Submitting a SBA Catastrophic Benefit Claim**

Once you have reached the $2,000 out-of-pocket, per-person per service/incident annual deductible, complete and submit the required catastrophic claim benefit form to the Fund Office for processing. Instructions are printed on the form. For additional information please contact the Fund Office.

Note: In the event a participant is not the subscriber to a New York City provided health plan, then coverage immediately defaults to the subscriber’s catastrophic benefit, if any.

Participants are obligated to immediately disclose to the Fund any catastrophic or similar coverage available.

**Subrogation**

Please note that all of the provisions stipulated under Section XI, “Subrogation”, apply to the Catastrophic Benefit provided under the Plan.
VIII. COORDINATION OF BENEFITS

THE COORDINATION OF BENEFITS

The Plan has a Coordination of Benefits (COB) feature, which prevents duplication of payments when participants or their eligible dependents have coverage under more than one group plan. When you submit claims to the Fund Office, you must indicate your other coverage, if applicable. The Fund will then be able to coordinate your benefits with your other coverage. When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all group plans will not exceed 100% of the total amount charged. If you and your spouse are both participants of the Fund and eligible for benefits, your benefit payments will also be coordinated not to exceed 100% of the total amount charged.

Where there is multiple coverage, the plan that is primarily responsible for paying a person’s expenses is the “primary” plan for that person. As the primary plan, it pays benefits first before any other insurer. Plans that pay after the primary plan are “secondary”. Here are the rules for determining when a plan is primary and secondary under this Plan.

- If the other plan does not have a COB provision, it is your primary coverage.
- If the other plan has a COB provision:
  - **For you (the current SBA member)** – the Plan is considered your primary plan.
  - **For your spouse or your domestic partner** – the plan provided by his or her employer is the primary plan.
  - **For your eligible dependent children** - The “birthday rule” determines which plan (yours or your spouse’s) is primary. The plan covering the spouse whose birthday falls earlier in the year is primary for your eligible dependent children. If you and your spouse have the same birthday, the plan covering you or your spouse the longest is primary.
IX. COBRA COVERAGE

COBRA CONTINUATION OF COVERAGE

You and your eligible dependent(s) have the right to continue Plan benefits and coverage (dental, prescription, and vision care) under this Plan on a self-pay basis. These benefits are the continuation of coverage (self-pay) as required by the Consolidation Omnibus Budget Reconciliation Act (COBRA).

COBRA continuation of coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event”. Specific qualifying events are listed below. COBRA continuation coverage is offered to each person who is a “qualified beneficiary”. A qualified beneficiary, generally, is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, members, their spouses and their dependent children may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA coverage.

Each qualified participant or beneficiary has an independent right to elect continuation coverage. You must contact the Fund Office in order to request a COBRA notification and election application for continuation coverage. The Fund Office will send Plan participants an election application within fourteen (14) days after it receives notice that a qualifying event has occurred.

If you wish to receive continuation coverage you must complete the COBRA election application provided to you by the Fund Office and return it to the Fund Office within sixty (60) days of receiving the election application. Additionally, you must make your first payment within forty five (45) days of submitting your COBRA application to the Fund Office.

Generally, you may not elect coverage at this time for a spouse or dependent children who are not currently covered under the Plan. Coverage for such individuals, however, may be obtained during the Plan’s open enrollment period(s). However, children who are born to, or placed for adoption with, a covered employee during the period of the employee’s continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. If a covered employee who is a qualified beneficiary has not elected COBRA coverage, then any newborn or adopted child of the employee born or adopted after the qualifying event is not a qualified beneficiary.

Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan’s rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying events. The maximum coverage period for such child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child’s birth or placement for adoption). In order to add a newly acquired dependent, you must notify the Fund Office within thirty (30) days of the birth or placement for adoption and timely pay the required premium.

ACTIVE NONLINE-OF-DUTY SBA COBRA COVERAGE

COBRA continuation coverage for SBA funded benefits discussed herein is for dependents and spouses of active members who experience an active nonline-of-duty death. This benefit is provided to those spouses and dependents at no out-of-pocket cost. This benefit terminates when there is a change in social status. This benefit is funded by the SBA Widows and Children’s Fund.

QUALIFYING EVENTS
A qualifying event for COBRA continuation coverage means that one of the following occurrences which would otherwise terminate you and your dependent’s coverage in the absence of COBRA:

- Termination of your employment, other than for gross misconduct;
- Your work hours are reduced;
- Your death;
- Your entitlement to Medicare;
- Your divorce or legal separation;
- If your dependent child is no longer an eligible dependent under the terms of the Plan.

NOTIFYING THE FUND OF A QUALIFYING EVENT

It is you or your dependent’s responsibility to notify the Fund Office within thirty (30) days of the occurrence of any of the following qualifying events: your death, your termination, or reduced hours of your employment.

It is you or your dependent’s responsibility to notify the Plan Administrator and Fund Office within sixty (60) days of the occurrence of any of the following qualifying events: your divorce, your legal separation, or your dependent child ceases to be an eligible dependent.

THE ELECTION PERIOD

You and/or your dependent(s) may elect to continue coverage within sixty (60) days or the later of:

- The date you and/or your dependent(s) would otherwise lose coverage due to the qualifying events; OR

- The date you and/or your dependent(s) are notified of your right to elect the continuation coverage. To elect COBRA continuation of health coverage, the COBRA eligible person must complete “COBRA Continuation of Coverage Application” provided by New York City. To indicate your interest in electing the Fund’s COBRA continuation coverage, you should answer yes to the question on the City COBRA application form that asks “Do you wish to purchase benefits from your Welfare Fund?” and notify the Health & Welfare Fund Office directly. To expedite processing you should send a copy of the completed City COBRA application form to the Fund Office. If you do not purchase City COBRA but would like to elect Health & Welfare Fund COBRA continuation coverage, write to the Health & Welfare Fund Office directly.

Note: The election of City COBRA does not automatically enroll you in COBRA for the SBA Health & Welfare Fund. You must indicate on the City COBRA form that you wish to enroll in COBRA from your Health & Welfare Fund. Elected benefits will be continued provided that:

- The election application is duly completed and returned to the Plan Administrator within the 60 day period noted above; AND

- The required payment is made within 45 days of submitting the election application to the Fund Office (submitted directly to the Fund Office and remitted to the Fund on your behalf).

THE COBRA COVERAGE CONTINUATION PERIOD
If you make timely payments according to the rules set forth in this summary plan description, your benefit continuation coverage may continue, on a self-pay basis as follows:

A. Coverage for you and/or your dependent(s) may be continued for up to eighteen (18) months, if coverage terminated due to your:
   - Termination of employment, other than for gross misconduct; OR
   - Reduced work hours that result in a loss of coverage.

The eighteen (18) month period of continuation may be extended an additional (eleven) 11 months if at the time of the qualifying events described above you or your dependent(s) are determined to be disabled by the Social Security Administration. Proof of disability must be provided to the Plan Administration within sixty (60) days of the date the Social Security Administration makes the determination. This extended period of continuation coverage applies only to the person who has been determined to be disabled by the Social Security Administration.

B. Coverage for your dependent may be continued for up to thirty six (36) months, coverage terminated due to:
   - Your death; OR
   - Your divorce, legal separation, or termination of a domestic partnership; OR
   - With respect to your dependent child, his or her ceasing to satisfy the Fund’s definition of an eligible dependent.

C. Coverage for your dependent child may be continued for up to age 29, coverage terminated due to:
   - His or her ceasing to qualify for full-time student status.

If your dependent’s coverage is continued for reasons listed under item (A) in this section and during the initial Continuation Period a qualifying event occurs which entitles the dependent to continue coverage under item (B) of this section, your dependent may elect to continue coverage up to a combined maximum of thirty-six (36) months.

You and/or your dependent(s) who elect to continue coverage shall be solely responsible for the payment of the cost of such continued coverage.

If an election is made after the qualifying event, payment for continuation coverage during the period preceding the election must be made within forty-five (45) days of the election. Therefore, the payment may be made in monthly installments.

**THE TERMINATION OF COBRA COVERAGE**

COBRA continuation of coverage terminates under the Plan for any of the following reasons:

D. The group health coverage provided to you is terminated (and the plan sponsor is not required by COBRA to provide you with other group health coverage that it maintains, if any);
E. The premium for continuation coverage is not paid in a timely manner (within the applicable grace period);

F. The individual becomes, after electing COBRA coverage, covered under another group health plan (as an employee or otherwise) that does not contain any pre-existing condition exclusion or limitation applicable to the individual. This may not apply if you or your dependent(s) have a pre-existing condition which is not covered under the new Plan. Contact the Plan Administrator for additional information when you and/or your dependent(s) become covered under another group plan;

G. The date of the applicable period of continuation coverage is exhausted;

H. The individual becomes, after electing COBRA coverage, enrolled in Medicare (Part A, Part B, or both); or

I. The first day of the month which begins thirty (30) days after you or your dependent(s) receive a final determination from Social Security that you or your dependent(s) are no longer disabled, in situations where the qualifying event was termination of employment or reduction in hours and where COBRA coverage was being continued for up to twenty nine (29) months (the eighteen (18) month period of continuation may be extended an additional eleven (11) months under circumstances described in this summary plan description). You are required to notify the Fund Office within thirty (30) days of any such final determination.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud). You will be responsible for all costs of coverage the Fund incurs as a result of your failure to immediately notify the Fund Office of the occurrence of one of the terminating events described above.

**COBRA RATES AND PAYMENTS**

Generally, each qualified participant or beneficiary is required to pay the entire cost of continuation coverage. The amount that you and other qualified participants or beneficiaries will need to pay will be one hundred and two percent (102%) (as provided for under the law) of the cost to the Fund for coverage of a similarly situated participant or beneficiary who is not receiving continuation coverage.

**Note:** If your qualifying event was your involuntary termination of employment that occurred on or after September 1, 2008 through March 31, 2010, you may be eligible for a premium reduction under the American Recovery and Reinvestment Act of 2009 (“ARRA”), as amended by the Department of Defense Appropriations Act and the Temporary Extension Act of 2010. This provision is subject to extension by federal law. For more information on the specifics and availability of this premium reduction subsidy contact the Fund Office.

The monthly premium rates may be adjusted due to changes in coverage. Even in the absence of any changes in coverage, premiums charged for continuation coverage may change on a yearly basis or as otherwise permitted by applicable law. After you or your family members experience a qualifying event and notify the Fund of said event, you will receive an election application that notifies you of the available benefits and actual premium that will apply.

If you (or another qualified beneficiary) elect COBRA continuation coverage, you must make your first premium payment for continuation coverage at the same time you make your coverage election and mail it into the Fund Office within sixty (60) days of receiving the COBRA notification from the Fund Office. If you (or another qualified beneficiary) do not make your first premium payment within this 60 day
period, you (or the qualified beneficiary, as applicable) will lose all rights to COBRA coverage under the Plan and your coverage will terminate (as of the date it would otherwise terminate under the Plan).

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Payment is due on the first day of the month for which the payment applies. That means that the payment for coverage for the month of June is due on June 1. As long as you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without a break.

Although periodic payments are due on the dates described above, you will be given a period of thirty (30) days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation of coverage under the Plan and your coverage will terminate as of the last date for which you made a timely payment. At the discretion of the Trustees and the Fund Office, the participant will be held responsible for all costs and fees incurred by the Fund during the aforementioned grace period corresponding to coverage for the individual.

**NOTIFICATION OF COBRA CONTINUATION COVERAGE**

Full details of COBRA continuation coverage will be furnished to you or your dependent(s) when the Fund Office receives notice that one of the qualifying events has occurred. Therefore, participants and beneficiaries must contact the Fund Office after one of those qualifying events according to the guidelines stated above.

**All notifications are to be submitted to:**

Sergeants Benevolent Association Health & Welfare Fund  
35 Worth Street  
New York, New York 10013  
T: 212-431-6555

**If You Have Questions:**

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

**Keep the Plan Informed of Changes:**

In order to protect your family’s rights, you should keep the Fund Office informed of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you send to the Fund Office.
X. APPEAL PROCEDURE

All Plan rules set forth in this summary plan description are uniformly applied by the Fund Office. The Trustees, and any person or persons it designates, including the Fund Office, has the exclusive right, power, and authority, in its sole discretion to administer, apply and interpret the Plan (according to Section XIII, “Interpreting the Plan”), including this summary plan description and any other plan documents, and to decide all matters that arise in the operation and administration of the Fund. The action of the Fund Office or any designee is subject to review by the Board of Trustees.

A participant or beneficiary may request a review of an action made by the designees of the Trustees, including the Fund Office, only when he or she believes that there are extenuating circumstances applicable warranting a review. A participant or beneficiary may appeal and request the review of an action by submitting written notice to the Trustees within sixty (60) days of the receipt of the notice of denial. At the time of making the appeal, the appellant shall provide any and all relevant documentation necessary to substantiate his or her claim.

The Trustees shall act on the appeal within a reasonable period of time and render their decision to the appellant in writing. Any and all determinations and interpretations made by the Trustees are final and binding on all participants, beneficiaries and any other individuals claiming benefits under the Plan. Participants must exhaust all the administrative remedies called for in this summary plan description.

All appeals shall be directed to:

Fund Administrator
Sergeants Benevolent Association Health & Welfare Fund
35 Worth Street
New York, NY 10013
XI. SUBROGATION UNDER THE PLAN

THIRD PARTY REIMBURSEMENT or SUBROGATION

Subrogation seeks to conserve the assets of the Plan by imposing the expense for accidental injuries suffered by participants, including eligible dependents, on those responsible for causing such injuries. The Plan shall have the right to, and in all cases, will seek to recover from you, your dependents and/or any other person, entity or trust in possession of such funds sought by the Plan, all benefits paid on your or your dependent's behalf by this Plan for injuries or disabilities that you or your dependents have suffered for which you or they recover monies in a "third party" claim or lawsuit or settlement thereof. The Plan may seek such recovery through subrogation and/or any other equitable or legal relief available under state and/or federal law.

If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the Plan for benefits and receive such benefits, the Plan shall then have a first priority lien for the full amount of the benefits that are paid to you and/or your dependents should you seek to recover any monies from the third party that caused, contributed to, or aggravated the injuries. These monies may come directly from the third party, his or her insurance company, or any other source (including, but not limited to, any person, corporation, entity, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile coverage or any other insurance policy or fund).

We strongly recommend that if you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, the Plan cannot and does not pay for the fees your attorney might charge you. The Plan does not require you to seek any recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Plan for any of the benefits that you applied for and accepted. However, in the event that you do not pursue any and all third parties, you authorize the Plan to pursue, sue, compromise or settle (in the Plan's discretion), any such claims on your behalf and you agree to execute any and all documents necessary to pursue such claims, and you agree to fully cooperate with the Plan in the prosecution of any such claims.

Should you seek to recover any monies from the third party that caused your injuries, you must give written notice to the Plan Administrator within ten (10) days after either you or your attorney first attempt to recover such monies, or institute a lawsuit, or enter into settlement negotiations with another or take any other similar action. You must also cooperate with the Plan's reasonable requests concerning the Plan's subrogation and restitution rights and keep the Plan informed of any important developments in your action. You must also provide the Plan with any information or documents, upon request, that pertain to or are relevant to your action. If litigation is commenced, you are required to give at least five (5) days written notice to the Plan Administrator prior to any action to be taken as part of such litigation, including, but not limited to any pre-trial conferences or other court dates. Representatives of the Plan reserve the right to attend such pre-trial conferences or other court proceedings.

The Plan's lien arises through operation of the Plan. No additional restitution agreement is necessary. By accepting benefits from the Plan, you agree that you will comply in a timely fashion with any and all requests from the Plan for documentation concerning any legal proceedings, settlement negotiations and/or medical information that may give rise to or affect the Plan's right to subrogation and/or restitution.

The Plan's lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from the third part, his insurance carrier and/or any other party settling on his behalf. By applying for and receiving benefits from the Plan in such third party situations, you agree to restore to the Plan the full
amount of the benefits that are paid to you and/or your dependents from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his insurance carrier and/or any other party settling on his behalf, if paid directly to you, will be held by you in a constructive trust for the Plan.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his insurance carrier and/or any other party settling on his behalf, and paid to a person or entity other than you, including but not limited to, a trust, an attorney or an agent thereof, shall be held by such other person, entity or trust in constructive trust for the Plan. The Plan reserves the right to seek recovery from such persons, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Plan's subrogation or restitution rights.

By applying for benefits, you agree that any lien the Plan may seek will not be reduced by any attorney fees, court costs or disbursement that you and/or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the common fund doctrine for the recovery of attorney's fees.

In the event that you fail to notify the Plan as provided for above, and/or fail to restore to the Plan such funds as provided for above, the Plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold or offset any other monies that might be due you from the Plan for past or future claims, until such time as the Plan's lien is discharged and/or satisfied.

Any and all amounts received from a third party by judgment, settlement, or otherwise, must be applied for first to satisfy your restitution obligation to the Plan for the amount of medical expenses paid on behalf of a participant or beneficiary. The Plan's lien is a lien of first priority for the entire recovery of funds paid on your behalf. Where the recovery from the third party is partial or incomplete, the Plan's right to restitution takes priority over the participant's or beneficiary's right of recovery, regardless of whether or not the participant or beneficiary has been made whole for his or her injuries or losses. The Plan does not recognize and is not bound by any application of the "make whole" doctrine.
XII. AMENDMENT OR 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 Trustees adopt 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 which established the Fund and governs its obligations.

Your coverage and your dependent’s coverage terminate at 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 payments;
- When there is a failure to notify the Fund of a participant’s change in their social status;
- When the City of New York or the quasi-public Agency, Authority, Board or Corporation ceases to make contributions on your behalf to the Fund; OR
- Your dependent’s coverage will terminate when they are no longer your eligible dependents.

All benefits provided under this Plan have been made available by the Trustees and are always subject to modification or termination at the prudent discretion of the Trustees. No participant acquires a vested right to benefits under the Plan either before or after his or her retirement.

The Trustees reserve the right, in their sole discretion, to: expand, amend, modify or cancel the benefits for participants, in whole or in part, at any time; change eligibility requirements or the amount of the direct payments; and otherwise exercise their prudent discretion as plan fiduciaries at any time without legal right or recourse by a participant or any other person.

All benefits provided under the Plan and eligibility rules for members and dependents: are not guaranteed; may be changed or discontinued by the Trustees at any time, in their sole and absolute discretion; and are subject to the rules and regulations adopted by the Trustees.

In accordance with Section XV, “Failure to Disclose,” any participant or beneficiary who willfully and knowingly engages in any activity intended to defraud the Plan will face loss of coverage under the Plan, will be held personally liable to the Fund for all costs/expenses incurred by the Fund, and will be subject to all other legal remedies available to the Fund.
XIII. INTERPRETING THE PLAN

The Board of Trustees, and any person or persons it designates, has the exclusive right, power, and authority, in its sole discretion to administer, apply and interpret the plan, including this summary plan description and any other plan documents, and to decide all matters that arise in the operation and administration of the Fund.

Without limiting the generality of the foregoing, the Trustees, and their designates, have the sole and absolute authority to:

- Interpret all the terms and provisions of the Plan;
- Take all actions and make all decisions related to eligibility for, and the amount of, benefits under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Plan;
- Decide questions (both legal and factual), all matters, and make factual determinations related to eligibility and the calculation and payment of benefits, and any other issues arising under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the official Plan documents, including this summary plan description;
- Approve or deny benefit claims;
- Determine the standard of proof required in any case; AND
- Process and approve or deny benefit claims and rule on any benefit exclusions.

Please note that the above list is for illustration purposes only and is not meant to be exhaustive of the types of determinations and interpretations under the control of the Board of Trustees or its designees.

GENDER and NUMBER

Words used in the masculine shall be read and construed in the feminine where applicable. Wherever required, the singular of any word used in this Plan shall include the plural and the plural may be read in the singular.
XIV. HIPAA PRIVACY POLICY

PRIVACY OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the American Recovery and Reinvestment Act of 2009 (ARRA) give you certain rights with respect to your health information, and it also imposes certain obligations on the Plan. This specific information is referred to as “protected health information.” Protected health information will be disclosed to the Plan Sponsor only for the Plan Sponsor to carry out “plan administrative functions” as such term is defined under the privacy regulations published under HIPAA (45 C.F.R. Parts 160 and 164) and within the requirements of HIPAA. The Plan Sponsor will use or disclose protected health information only for plan administration functions related to treatment, payment, and health care operations as permitted or required by any of the Fund’s documents or as required by law.

In order for the Plan to disclose any protected health information to the Plan Sponsor, the Plan Sponsor must follow the specific policies and procedures set forth in the Fund’s “HIPAA Privacy Rules Policy Statement” and the “Notice of Privacy Practices” in compliance with the law. Please reference these two documents which have been distributed to participants and beneficiaries along with this summary plan description.

The Plan will not disclose protected health information to the Plan Sponsor unless disclosures are explained in the Notice of Privacy Practices and Privacy Rules Policy Statement. The Plan will not disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless it receives the express written authorization of the participant or beneficiary to do so.

The Plan sponsor will report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under this summary plan description or the Notice of Privacy Practices and the Privacy Rules Policy Statement that have been distributed to all Plan participants.
PARTICIPANTS’ FAILURE TO DISCLOSE

In order to protect yours and your family’s rights, it is imperative that all participants and beneficiaries keep the Fund Office up-to-date of their current family/social status, address, telephone number, and e-mail address. You should also keep a copy, for your records, of any notices or correspondence you send to the Fund Office.

If it is found that a participant or beneficiary failed to notify the Fund Office immediately following a change in that participant or beneficiary’s social/family status, makes a false statement, fails to disclose requested information, or furnishes fraudulent or incorrect information, the authorized representatives of the Fund Office, Trustees, or any of their designees in their sole and absolute discretion reserve the full authority to deny, suspend or discontinue the participant or beneficiary’s benefits provided under the plan at any time and for any length of time.

Furthermore, a failure to notify the Fund Office of a change in social/family status will also leave the participant or beneficiary personally responsible for all expenses and/or costs incurred by the Fund retroactive to the effective date of the assigned coverage whereby the dependent was ineligible for benefit coverage under the Plan, as a result of the Fund administering benefits to members and dependents in this fraudulent situation.

Any participant or beneficiary who willfully and knowingly engages in an activity intended to defraud the Fund will face loss of coverage under the Plan, will be held personally liable to the Fund for all costs and/or expenses incurred by the Fund, and will be subject to all other legal remedies available to the Fund at that time.
XVI. FUND INFORMATION

Board of Trustees of the Sergeants Benevolent Association Health & Welfare Fund

Edward D. Mullins, Chairman
Robert Ganley
Robert W. Johnson, Esq.
Vincent J. Vallelong
Gary DeRosa
Paul A. Capotosto
Vincent Guida

Sergeants Benevolent Association Health & Welfare Fund

35 Worth Street
New York, NY 10013
T: (212) 431-6555
F: (212) 431-6487

Fund Number: 501

Plan Year - Fiscal Year: July 1 to June 30

Type of Plan: Welfare Benefits