ATU LOCAL 726 BENEFITS FUND
PLAN AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

The ATU Local 726 Benefits Fund (the "Fund") provides benefits for Amalgamated Transit Union Local 726 bargaining unit members, and for certain spouses and eligible dependents of those members.

This ATU Local 726 Benefits Plan (the "Plan") is established to provide the health benefits funded by the Fund, and is intended to constitute a welfare benefit plan as amended from time to time.

The Plan is administered by a three-member Board of Trustees appointed by Amalgamated Transit Union Local 726 (the "Board of Trustees"). Contact information for the Board of Trustees is listed in Article 9 of this document.

Interpretations of the terms of the Plan, including, without limitation, determinations of eligibility for participation in the Plan, are made by the Board of Trustees in its sole and absolute discretion. Any inquiry relative to interpretations or other such matters regarding the Plan should be referred to the Board of Trustees. The Board of Trustees is not obligated, bound, or responsible for opinions, information, or representations coming from other sources.

The Plan, or any of the benefits described in the Plan, may be amended, modified, or terminated by ATU Local 726 in its sole and absolute discretion at any time and from time to time. The Plan is governed by the terms described in this Plan and Summary Plan Description and the Declaration of Trust of Amalgamated Transit Union Local 726 (the "Fund Agreement"). For a complete understanding of the terms of the Plan, you may wish to review, in addition to this document, the Fund Agreement, and any applicable contract or arrangement between the Plan and a Benefit Provider.

Plan and Benefit Highlights

This section briefly describes the benefits provided under the Plan and certain eligibility terms. The benefits are described in greater detail in the accompanying benefit Program Documents. The terms of the Plan are set forth in sections that follow this Plan and Benefit Highlights section. Please read the Program Documents and Plan for additional information.

Benefits Provided Under the Plan

The following benefits are provided under the Plan.*

Benefits	**The Claims Administrator for the Benefit**
Vision Please see Appendix B, which is available on-line at www.ATU726benefitsfund.com for more detailed information about the Plan's vision benefits. A short description of the vision benefits follows the "Other Information about the Plan" section.	General Vision Services (GVS) 520 Eighth Avenue Suite 901 New York, NY 10018 855-653-0586 www.generalvision.com
Dental – Dentcare Please see Appendix C, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's Dentcare dental benefits. A short description of the Dentcare dental benefits follows the "Other Information about the Plan" section.	Dentcare Delivery Systems, Inc. 333 Earle Ovington Blvd., Suite 300 Uniondale, NY 11553-3608 800-468-0600 www.healthplex.com
Dental – CIGNA P2X00 (Low) Please see Appendix D, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's CIGNA P2XOO (low) dental benefits. A short description of the CIGNA dental benefits follows the "Other Information about the Plan" section.	CIGNA 140 East 45th Street New York, NY 10017 800-CIGNA24 (800-244-6224) www.cigna.com
Dental – CIGNA P1-00 (High) Please see Appendix E, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's CIGNA P1-00 (high) dental benefits. A short description of the CIGNA dental benefits follows the "Other Information about the Plan" section.	CIGNA 140 East 45th Street New York, NY 10017 800-CIGNA24 (800-244-6224) www.cigna.com

Life Insurance Please see Appendix F, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's Aetna life insurance benefits. A short description of the life insurance benefits follows the "Other Information about the Plan" section.	Aetna Life Insurance Company PO Box 14549 Lexington, KY 40512-4549 800-523-5065 800-238-6239 (fax) www.aetna.com

* If you are a member of ATU Local 726 and enrolled in the Empire BlueCross/BlueShield High Option, your dental benefits are provided through GHI Preferred Dental and are administered by the MTA. You may contact GHI Preferred Dental at 212-501-4444 or MTA Business Service Center at 646-376-0123, or go on the portal at mtabsc.info.

Who Is Eligible for benefits under the Plan?

The following individuals are eligible to participate in the Plan if they satisfy the eligibility provisions of the Plan, which are described in Article 2 of the Plan.

- An Eligible Employee is an individual who is an employee of the New York City Transit Authority covered by the collective bargaining agreement between the New York City Transit Authority and the Amalgamated Transit Union Local 726.

- A spouse or dependent child of an Eligible Employee as determined under the applicable benefit Program. When these Dependents are covered by the Plan, they are called Beneficiaries.

You may be required to provide proof that an individual qualifies as a Dependent. Please see Article 2 of the Plan and the Program Documents for more details about eligibility requirements.

When does your participation in the Plan end?

Your coverage under the Plan ends on the earliest of the following dates:

- the date that you are no longer an Eligible Employee;

- the date that either the Plan or the Program in which you participate terminates;

- the first day of the month for which any required Participant contribution is not received; or

- the first day of the month following the date on which you notify the Plan Administrator that you wish to terminate coverage in the Program.

For Beneficiaries, coverage under the Plan ends on the earliest of the dates above or the date that you cease to be a Beneficiary for any reason, including without limitation, with respect to Dependents, the death of the Eligible Employee.

Coverage under the life insurance benefit ends on the earliest of the dates above or the following dates:

- the last day of the month following the month in which a non-FMLA leave of absence begins; or

- the last day of the month following the month in which a layoff begins.

Please see Article 2 of the Plan for more details about termination of participation. Note that some programs may have earlier or later termination dates. Please review the Program Documents for more information.

Other Information about the Plan

- The name of the Plan is the "ATU Local 726 Benefits Plan."

- The administrator for the Plan is Extensive Benefits, Inc. You may contact them at:

  Teresa Freeman
  Extensive Benefits, Inc.
  P.O. Box 813546
  Smyrna, Georgia 30081
  Email: Info@extensivebenefits.com
  Phone: 1-888-416-4211
  Fax: 1-404-585-3508

- The contact information for the claims administrators/insurers for the specific benefits is listed above and in Appendix A below.

- The Plan Year begins January 1 and ends December 31.

- The Plan's HIPAA Privacy Notice, which describes how medical information about you may be used and disclosed by the Plan, is set forth below in "Addendum – Privacy Notice."

- Information about COBRA is set forth below in "Addendum – COBRA General Notice."

ATU LOCAL 726 BENEFITS FUND
VISION BENEFITS

IN-NETWORK

Benefit	Description	ATU Co-Pay	Frequency
Vision Exam	Focus on your eyes and overall wellness	0	Every 12 Months
Benefit	**Description**	**ATU Co-Pay**	**Frequency**
Frames	$275 allowance for the 1st year, $300 for the 2nd year and $325 for the 3rd year from a wide selection of frames in the GVS collection	0	Every 12 Months
Lenses	Single Vision	0	Every 12 Months
	Lined Bifocal	0	
	Lined Trifocal	0	
	Blended Bifocal	0	
	Progressive Lenses	0	
Lens Options	Tints	0	
	Scratch Guard Coating	0	
	Ultra Violet Coating	0	
	Polycarb Lenses for children 19 and under	0	
	Anti-reflective Coating	0	
	Polycarb Lenses over 19 (SV & BF)	$30.00	
	Transition SV	$60.00	
	Transition BF	$80.00	
	Transition Varilux or similar	$210.00	
	Varilux Comfort Progressive or similar	$150.00	
	Hi Index SV	$75.00	
	Hi Index BF	$75.00	
	Hi Index 1.6 SV	$69.00	
	Hi Index 1.66 MF	$75.00	
	Premium AR	$48.00	
	Ultra AR	$60.00	
	Polarized	$74.00	
Benefit	**Description**	**ATU Co-Pay**	**Frequency**
Contact Lenses	One Year Supply of Disposables 1st year - $150 allowance for upgraded contact lenses 2nd year - $175 allowance for upgraded contact lenses 3rd year - $200 allowance for upgraded contact lenses Exam/fitting fee included	0	Every 12 Months
Additional Savings	40% off additional glasses and sunglasses, including lens options above that are not covered. 25% discount for members/dependents for eyeglass cases, cleaning cloths, eyeglass chains etc. (where applicable)		

OUT OF NETWORK

(Reimbursements will increase by 10% the second year and 10% the third year over the 3 year contract)

Benefit	Description	Out of Network Reimbursement	Frequency
Vision Exam		$20.00	Every 12 Months
Benefit	**Description**	**Out of Network Reimbursement**	**Frequency**
Frames		$30.00	Every 12 Months
Lenses	Single Vision	$25.00	Every 12 Months
	Lined Bifocal	$30.00	
	Lined Trifocal	$30.00	
	Progressive Lenses	$30.00	
Benefit	**Description**	**Out of Network Reimbursement**	**Frequency**
Contact Lenses		$60.00	Every 12 Months

Group Benefit Page

Group Name:	**ATU Local 726 Employee Benefits**
Group Number:	**GG-009A/GG-009AC**
Effective Date:	**April 1, 2015**
Plan Number:	**N/A**
Benefit Period:	**Calendar Year**

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. Many 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. Unless otherwise noted, patient copayments will be the same when services are rendered by 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 we 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.

Dependent Eligibility - Dependent Children are covered up to their 19th birthday, or up to their 23rd birthday if a full-time student.

Orthodontics - Dependent Children up to age 19.

ATU Local 726 Employee Benefits
Member Copayment Schedule - GG-009A/GG-009AC

Category	Services	Member Pays
Diagnostic & Preventive	Periodic Oral Examination (once every 6 months)	No Charge
	Full Mouth Series X-Rays (once every 36 months)	No Charge
	Periapical, First Film	No Charge
	Bitewings, Four Films	No Charge
	Prophylaxis, Adult/Child	No Charge
	Fluoride Treatment	No Charge
Basic	Amalgam, 1 Surface	No Charge
	Amalgam, 2 Surfaces	No Charge
	Amalgam, 3 Surfaces	No Charge
	Amalgam, 4+ Surfaces	No Charge
	Resin-Based Composite, 1 Surface, Anterior	No Charge
	Resin-Based Composite, 2 Surfaces, Anterior	No Charge
	Resin-Based Composite, 3 Surfaces, Anterior	No Charge
	Resin-Based Composite, 4+ Surfaces, Anterior	No Charge
	Pulpotomy	No Charge
	Root Canal Therapy, Anterior	No Charge
	Root Canal Therapy, Bicuspid	No Charge
	Root Canal Therapy, Molar	No Charge
	Apicoectomy, Per Root, Anterior	No Charge
	Gingivectomy, Per Quad	No Charge
	Osseous Surgery, Per Quad	No Charge
	Scaling/Root Planing, Per Quad	No Charge
	Routine Extraction	No Charge
	Surgical Extraction	No Charge
	Soft Tissue Impaction	No Charge
	Partial Bony Impaction	No Charge
	Full Bony Impaction	No Charge
	Alveolectomy, Per Quad, w/Extraction	No Charge
	Palliative Treatment	No Charge
Major	Porcelain with High Noble Metal Crown	No Charge
	Full Cast High Noble Metal Crown	No Charge
	Recementation Crown/Bridge	No Charge
	Stainless Steel Crown (Primary Tooth)	No Charge
	Post and Core, Casted	No Charge
	Complete Upper or Lower Denture	$50.00
	Partial Upper or Lower Denture, Cast Base	50.00
	Denture Repairs	No Charge
	Porcelain with High Noble Metal Pontic	50.00
	Porcelain with High Noble Metal Abutment	50.00
	Full Cast High Noble Metal Abutment	50.00
Orthodontics	Maximum Case Fee 24 Months	$950.00

Managed Care

Our managed care dental plans feature:

- No claim forms
- No deductibles
- Coverage for pre-existing conditions

Important

- Members must use dentists who participate in the Comprehensive Panel.
- Referrals are required to see a dental specialist.
- Members are responsible for all costs not covered by this dental plan.

This copayment schedule contains a general description of your Dental Care program for your use as a convenient reference. **Due to certain Exclusions and/or Limitations, all member copayments may not be applicable.** Prior to receiving any treatment, please obtain the Certificate of Insurance from your benefit administrator for Exclusions and Limitations. All benefits are governed by the provisions of your group's contract.

Underwritten by

DENTCARE DELIVERY SYSTEMS, INC.

Administered by

HEALTHPLEX. THE DENTAL BENEFIT EXPERTS℠

B-2007 Print 04/15 Eff. 04/15

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CIGNA DENTAL CARE® – DHMO[1]

ECONOMICAL, EASY-TO-USE DENTAL COVERAGE

Under your plan, you have coverage for **hundreds** of dental procedures. This overview shows you a small **sampling** of covered services and what you will pay compared to your estimated **cost without coverage**. See savings below!

Review your plan materials to understand how your plan works. For questions on the plan before enrollment, call **1.800.Cigna24 (1.800.244.6224)** and select the "Enrollment Information" prompt.

Regular dental visits may do more than brighten your smile. Receiving regular dental care often catches minor problems before they become major and more expensive to treat.

And there's an association between gum disease and other conditions, such as preterm birth, heart disease, stroke, diabetes and other health issues. So taking good care of your teeth and gums may help you live a healthier life.

Get the most value from your plan

Take advantage of your plan's preventive care services – certain services may be covered at no additional cost to you (see below for details). Your plan also covers many other dental services that can help you achieve and maintain a healthy mouth.

	What You'll Pay[2]	
Sampling of covered procedures	Cost with Cigna Dental Care	Estimated cost without dental coverage
Adult cleaning (two per calendar year each at $0) (additional cleanings available at $35 each)	$0	$70–$136 each
Child cleaning (two per calendar year each at $0) (additional cleanings available at $25 each)	$0	$53–$102 each
Periodic oral evaluation	$0	$40–$76
Comprehensive oral evaluation	$0	$62–$118
Topical fluoride (two per calendar year each at $0) (additional topical fluoride available at $15 each)	$0	$28–$53
X–rays – (bitewings) 2 films	$0	$33–$63
X–rays – panoramic film	$0	$84–$161
Sealant – per tooth	$0	$42–$80
Amalgam filling (silver colored) – 2 surfaces	$0	$118–$226
Composite filling (tooth–colored) – 1 surface, Anterior	$0	$120–$231
Molar root canal (excluding final restoration)	$75	$852–$1,640
Comprehensive orthodontics – child (up to 19th birthday) – Banding	$370	$1,042–$2,005
Periodontal (gum) scaling & root planing – 1 quadrant	$15	$179–$344
Periodontal (gum) maintenance	$15	$109–$209
Removal/extraction of erupted tooth	$0	$120–$231
Removal/extraction of impacted tooth	$55	$370–$712
Crown – porcelain fused to high noble metal	$50	$849–$1,634
Implant supported retainer for porcelain fused to metal fixed partial denture	$530	$1,097–$2,112
Occlusal appliance, by report (for treatment of TMJ)	$135	$640–$1,233

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Offered by: Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, or their affiliates

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Know what's important to you

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays, and more
- **Basic care –** tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, and dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for (gum) disease, specialty care (with an approved referral), and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Teeth whitening** – using take-home bleaching trays and gel

Finding a network dentist is easy.

There are several ways to choose your network general dentist:

- Find a dentist at Cigna.com. Our online dental directory is updated weekly.
- Call **1.800.Cigna24** (**1.800.244.6224**) to speak with a customer service representative. Our representatives can send you a customized dental directory listing via email.

Key plan features

- No deductibles – you don't have to reach a certain level of out-of-pocket expenses before your insurance kicks in.
- No dollar maximums – you don't have to worry about your coverage running out after your covered expenses reach a certain dollar amount.
- Easy to understand plan – the fees you pay your dentist are clearly listed on your Patient Charge Schedule (PCS).
- There are no claim forms to file and no waiting periods for coverage.
- The network general dentist you choose will manage your overall dental care.
- Covered family members can choose their own network general dentists – near home, work or school.
- You don't need a referral for children under seven to visit a network pediatric dentist. And you don't need a referral to see a network orthodontist.
- There's no age limit on sealants, which help prevent tooth decay.
- Your plan covers certain procedures to help detect oral cancer in its early stages.
- 24/7 access to the Dental Information Line – this line is staffed by trained professionals who can help if you have questions about dental treatment and clinical symptoms.

Exceptions

Procedure	Limit
Exams	Two per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Crowns and inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and partials	Replacement every 5 years
Relines, rebases	One every 36 months
Adjustments	Four within the first 6 months after installation
Prosthesis over implant	Replacement every 5 years if unserviceable and cannot be repaired
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months when listed on your PCS

Referrals are required for specialty care services. Specialty treatment plans require payment authorization for services to be covered under your plan,except for Pediatrics, Orthodontics and Endodontics. You should verify with your Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna before treatment begins.

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's usual fees. There is no coverage for:

- Or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the united states government or by a state or municipal government if the person had no insurance
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- The charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[3]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- Prescription medications
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[4]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[4]
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

This document outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2012 and are intended to reflect national average charges as of January 2015 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2011 Cigna DHMO geographical membership distribution.
3. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
4. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under you PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided and are not agents of Cigna.

DHMO insurance coverage is set forth on the following policy form numbers: CO, DE, FL, KS, NE, OH, PA, and VA: PB09. AR: HP-POL120; CA: CAPB09, CAVP/A09, or 91994D3; CT: PB09CT; IL: CG–CDC–ILL–POLICY; LA: HP-POL118; MA: HP-POL134; MI: HP-POL179; MO: PB09MO; MS: HP-POL117; NC: PB09.NC; NV: HP-POL132; NY: HP-POL130; OK: HP-POL115 (CHLIC) and GM6000 DEN201V1 (CGLIC); OR: HP-POL121; SC: HP-POL128; TN: HP-POL134; TX: PB09TX; UT: HP-POL129; WA: WAPOL05/11; and WI: HP-POL122.

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CIGNA DENTAL CARE® – DHMO[1]

ECONOMICAL, EASY-TO-USE DENTAL COVERAGE

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Regular dental visits may do more than brighten your smile. Receiving regular dental care often catches minor problems before they become major and more expensive to treat.

And there's an association between gum disease and other conditions, such as preterm birth, heart disease, stroke, diabetes and other health issues. So taking good care of your teeth and gums may help you live a healthier life.

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X–rays – panoramic film	$0	$84–$161
Sealant – per tooth	$0	$42–$80
Amalgam filling (silver colored) – 2 surfaces	$0	$118–$226
Composite filling (tooth–colored) – 1 surface, Anterior	$0	$120–$231
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Periodontal (gum) maintenance	$0	$109–$209
Removal/extraction of erupted tooth	$0	$120–$231
Removal/extraction of impacted tooth	$0	$370–$712
Crown – porcelain fused to high noble metal	$0	$849–$1,634
Implant supported retainer for porcelain fused to metal fixed partial denture	$0	$1,097–$2,112
Occlusal appliance, by report (for treatment of TMJ)	$0	$640–$1,233

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Offered by: Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, or their affiliates

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Know what's important to you

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays, and more
- **Basic care –** tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, and dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for (gum) disease, specialty care (with an approved referral), and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Teeth whitening** – using take-home bleaching trays and gel

Finding a network dentist is easy.

There are several ways to choose your network general dentist:

- Find a dentist at Cigna.com. Our online dental directory is updated weekly.
- Call **1.800.Cigna24** (**1.800.244.6224**) to speak with a customer service representative. Our representatives can send you a customized dental directory listing via email.

Key plan features

- No deductibles – you don't have to reach a certain level of out-of-pocket expenses before your insurance kicks in.
- No dollar maximums – you don't have to worry about your coverage running out after your covered expenses reach a certain dollar amount.
- Easy to understand plan – the fees you pay your dentist are clearly listed on your Patient Charge Schedule (PCS).
- There are no claim forms to file and no waiting periods for coverage.
- The network general dentist you choose will manage your overall dental care.
- Covered family members can choose their own network general dentists – near home, work or school.
- You don't need a referral for children under seven to visit a network pediatric dentist. And you don't need a referral to see a network orthodontist.
- There's no age limit on sealants, which help prevent tooth decay.
- Your plan covers certain procedures to help detect oral cancer in its early stages.
- 24/7 access to the Dental Information Line – this line is staffed by trained professionals who can help if you have questions about dental treatment and clinical symptoms.

Exceptions

Procedure	Limit
Exams	Two per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Crowns and inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and partials	Replacement every 5 years
Relines, rebases	One every 36 months
Adjustments	Four within the first 6 months after installation
Prosthesis over implant	Replacement every 5 years if unserviceable and cannot be repaired
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months when listed on your PCS

Referrals are required for specialty care services. Specialty treatment plans require payment authorization for services to be covered under your plan,except for Pediatrics, Orthodontics and Endodontics. You should verify with your Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna before treatment begins.

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's usual fees. There is no coverage for:

- Or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the united states government or by a state or municipal government if the person had no insurance
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- The charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[3]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- Prescription medications
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[4]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[4]
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

This document outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2012 and are intended to reflect national average charges as of January 2015 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2011 Cigna DHMO geographical membership distribution.
3. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
4. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under you PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided and are not agents of Cigna.

DHMO insurance coverage is set forth on the following policy form numbers: CO, DE, FL, KS, NE, OH, PA, and VA: PB09. AR: HP-POL120; CA: CAPB09, CAVP/A09, or 91994D3; CT: PB09CT; IL: CG–CDC–ILL–POLICY; LA: HP-POL118; MA: HP-POL134; MI: HP-POL179; MO: PB09MO; MS: HP-POL117; NC: PB09.NC; NV: HP-POL132; NY: HP-POL130; OK: HP-POL115 (CHLIC) and GM6000 DEN201V1 (CGLIC); OR: HP-POL121; SC: HP-POL128; TN: HP-POL134; TX: PB09TX; UT: HP-POL129; WA: WAPOL05/11; and WI: HP-POL122.

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Amalgamated Transit Union Local 726 Benefits Fund

Your Summary of Group Life Benefits

Basic Term Life

Coverage Effective Date: **04/01/2015**

Your Group Life Insurance Benefits

Protecting your greatest asset - your family

Am I eligible for Coverage?

You qualify if **you are an employee of the New York City Transit Authority covered by a collective bargaining agreement between the New York City Transit Authority and the Amalgamated Transit Union Local 726.**

If you are a new hire or have not been previously covered by the Fund's plan, you may need to complete a probationary or waiting period **30 days** before your coverage begins.

When does my coverage begin?

Your coverage up to the Guaranteed Issue Amounts will begin on **04/01/2015**, if you are actively at work.*	The "Guaranteed Issue Amount" is the most coverage you can get without having to provide proof of good health, known as "EOI". *Please review your policy documents for more information.
Coverage that requires proof of good health will begin after Aetna reviews and approves your "EOI" form.	You will have to provide proof of good health (EOI) for amounts over the "Guaranteed Issue Amounts". If Aetna does not approve your Evidence of Insurability (EOI) form, your coverage will be limited to the "Guaranteed Issue Amount". If you enroll late, you will need to provide proof of good health and be approved by Aetna to get *any* coverage.

How much coverage does the ATU Local 726 Benefits Fund provide?

Fund-Paid - Term Life

Your union pays for a benefit in the amount of:

- **You:** $75,000

Life insurance provides your loved ones with financial protection if you die. It can help pay your final expenses like funeral and burial; everyday living expenses like mortgage or rent, car payments and groceries; future expenses like college tuition payments.

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Amalgamated Transit Union Local 726 Benefits Fund

Your Summary of Group Life Benefits

What additional features should I know about?

Waiver of Premium Provision for Permanently and Totally Disabled Members	If you are unable to work at any reasonable job (any which you are suited to perform due to education, training or experience), you may be eligible to have your life insurance coverage extended at no cost.
Accelerated Death Benefit Provision (Included in all Aetna Life Insurance plans)	You may be eligible to receive up to 75% of your life insurance coverage if diagnosed with a terminal or serious medical condition.
AD&D Ultra® Features A benefit is paid to your surviving spouse/domestic partner or dependent children if you die in an accident.	**Seatbelt/airbag benefits:** If you or your dependent die from a motor vehicle accident while wearing a seatbelt, a benefit is paid. An added benefit is paid if an airbag inflated. **Educational benefit:** For your spouse and each eligible dependent child under 23. **Childcare Benefit:** For each dependent child under 13 to help pay for childcare. **Repatriation of Mortal Remains:** If you or your dependent die in an accident 200 miles or more from home, a benefit will be paid to transport the body to your hometown funeral home.
Conversion If your coverage ends or is reduced, you can convert your term life policy to a Whole Life Policy.	You may convert your basic coverage into a Whole Life Policy with rates based on your age at that time by paying premiums directly to Aetna. Whole life insurance is generally more expensive than term insurance so a change in your premium may apply. You will have 31 days to convert your coverage without answering any medical questions.
Portability If you leave your employer, you can take your term life plan with you.	You have an additional option to conversion. You can continue your basic life insurance as a term policy by paying premiums directly to Aetna. Term insurance is generally less expensive than Whole Life insurance but your rates will increase as you reach higher age bands. You will have 31 days to convert or port your coverage without answering any medical questions.
Aetna Life Essentials® (Included in all Aetna Life Insurance plans)	**Legal:** Create a will, living will, health care directive or a durable/financial power of attorney. **Financial:** Financial planning to help your beneficiaries maximize their life/AD&D Ultra payment. **Emotional:** Master-level social workers provide emotional support in the event of an advanced illness or disabling condition. **Physical:** Save on gym memberships, fitness equipment, eyeglasses, contact lenses and hearing aids.
Funeral Planning and Concierge Services	Advisory Assistance to help you and your family make decisions on all funeral-related issues. Planning advice and cost-comparison tools available 24/7 by phone and online.

ARTICLE 1
DEFINITIONS

Unless the context otherwise requires, the following terms shall have the meanings set forth below:

1.01 "Benefit Provider(s)" means those insurers, companies, and administrators with which the Board of Trustees contracts to provide benefits pursuant to the Program(s).

1.02 "Beneficiary" or "Beneficiaries" means any individual who is described in Section 2.01(b).

1.03 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

1.04 "Board of Trustees" means the persons from time to time who are acting collectively as the Board of Trustees appointed to control and manage the operation and overall administration of the Plan.

1.05 "Dependent" means a spouse or dependent child of an Eligible Employee as determined under the applicable Program.

1.06 "Eligible Employee" means any individual who is described in Section 2.01(a).

1.07 "Employer" means the New York City Transit Authority.

1.08 "Participant" means Eligible Employees and Beneficiaries described in Section 2.01 who satisfy the requirements for participation in the Plan and whose participation in the Plan has not, for any reason, terminated.

1.09 "Union" means the Amalgamated Transit Union Local 726.

1.10 "Plan" means the ATU Local 726 Benefits Plan effective April 1, 2015.

1.11 "Plan Administrator" means the Board of Trustees of the ATU Local 726 Benefits Plan. The Board of Trustees may delegate administrative functions to a third-party administrator from time to time.

1.12 "Plan Year" means January 1 through December 31.

1.13 "Program(s)" means the benefits described in the Appendix, as amended from time to time.

1.14 "Program Document" means (i) any summary plan description for the Plan that sets forth terms and conditions of any Program, and any supplements thereto, and (ii) all other plan documents, insurance policies, certificates of insurance, and other documents (each, if any) that set forth the terms and conditions of a Program, as may be amended from time to time. Any amendment to a Program Document will constitute automatically an amendment to the Plan.

1.15 "Summary Plan Description" means this booklet describing the terms and conditions of the Plan.

1.16 "Declaration of Trust" means the Declaration of Trust of Amalgamated Transit Union Local 726 effective January 20, 2015, and as amended from time to time, which is intended to constitute a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Code.

1.17 "Trust" means the property maintained in trust pursuant to the Declaration of Trust.

1.18 "You" means a Participant or, if used in an Appendix, a Participant who is eligible for the particular Program described in the Appendix.

ARTICLE 2
ELIGIBILITY AND PARTICIPATION; PARTICIPANT CONTRIBUTIONS

2.01 Eligibility for Participation in the Plan

You will become a Participant in the Plan if (i) you are an "Eligible Employee" or a "Beneficiary," as each term is defined below, and (ii) you satisfy any additional requirements applicable to specific Program(s) for which you may be eligible:

(a) An *Eligible Employee* is an individual who is an employee of the New York City Transit Authority covered by the collective bargaining agreement between the New York City Transit Authority and the Amalgamated Transit Union Local 726.

(b) A *Beneficiary* is an individual who is an eligible Dependent of an Eligible Employee.

The Plan Administrator – or as the case may be, a Benefit Provider – may require proof that an individual qualifies as a Dependent in accordance with rules that it or they may establish. You must provide the Plan Administrator with prompt written notice of any change in your family status, such as marriage, divorce, or a change in Beneficiary status. Participants will be held responsible for any costs of the Plan attributable to their failure to notify the Plan Administrator of a loss of Dependent status.

2.02 Eligibility and Enrollment for Specific Programs

Additional eligibility requirements may apply for participation in the Programs offered by the Plan. A list of the Programs offered by the Plan is set forth in Appendix A, and Program Documents are set forth in other Appendices.

2.03 When Does Participation End?

(a) Coverage under the Plan (including all of its Programs) will automatically end on the earliest to occur of the following dates:

(1) the date on which you cease to be an Eligible Employee;

(2) the date that either the Plan or the Program in which you participate terminates;

(3) the first day of the month for which any required Participant contribution is not received; or

(4) the first day of the month following the date on which the Participant or Beneficiary notify the Plan Administrator that he or she wishes to terminate coverage in the Program.

(5) for Beneficiaries, the date on which the Dependent ceases to be a Beneficiary for any reason, including, without limitation, the death of the Eligible Employee.

(b) Coverage under the life insurance benefit ends on the earliest of the dates above or the following dates:

(1) the last day of the month following the month in which a non-FMLA leave of absence begins; or

(2) the last day of the month following the month in which a layoff begins.

(c) If a Program Document provides for an earlier or later termination date, such termination date shall apply.

2.04 Participant Contributions

You may be required to pay contributions to participate in any or all of the Programs offered by the Plan. ATU Local 726, or its delegee, in its sole and absolute discretion, determines the amount of Participant contributions required to participate in any Program and may modify any Participant contributions that may be required to participate in any Program at any time and from time to time. Failure to pay timely Participant contributions may result in termination of your participation in the Plan and/or in the particular Program to which the contribution applies.

ARTICLE 3
BENEFITS

3.01 Benefits

You are entitled to benefits to the extent determined by the Board of Trustees from time to time. Until changed by ATU Local 726, the benefits shall be those offered under the Programs as set forth in the Appendices. Such benefits shall be subject to the provisions of the Program Document setting forth the terms and conditions pursuant to which such benefits are provided, and any condition or restriction imposed by a Benefit Provider or an administrator providing any benefit.

A description of the specific Plan benefits is set forth in the Appendices of this booklet.

3.02 Claims for Benefits

Rules for filing a claim for benefits vary with each particular Program: see the Program Documents for details.

3.03 Insurance Contracts

Some or all of the benefits provided under the Plan may, at the discretion of the Board of Trustees, be provided by the purchase of insurance contracts issued by one or more insurance companies. Any refund, rebate, dividend, experience adjustment, retroactive rates, proceeds from demutualization, or other similar payment under any insurance contract or service contract or Program shall be the property of and retained by the Plan.

3.04 Incorporation

The terms and conditions, including any limitations or restrictions, of each Program as set forth in the applicable Program Document are hereby incorporated by reference in this Plan document and constitute a part of the Plan.

ARTICLE 4
CLAIMS AND SUBROGRATION; PARTICIPANT RESPONSIBILITIES

4.01 In General

The Board of Trustees is responsible for establishing rules and regulations under which the Plan operates. Plan interpretations and other matters relating to the operation of the Plan are the sole responsibility of the Board of Trustees. The Board of Trustees may delegate, however, the responsibility for any benefits determination to the Benefit Provider for the Program under which such benefit is made available under the Plan. The Board of Trustees or a Benefit Provider, as the case may be, has the discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. The Board of Trustees will decide appeals of denials of claims by a third-party administrator or a Benefit Provider, as the case may be, or may delegate the responsibility for deciding appeals to a third party, including, without limitation, a Benefit Provider, in which case all references to the Board of Trustees shall be deemed to refer to its delegee in the provisions governing appeals.

4.02 Making a Claim for Benefits

Claims for Program benefits will be processed pursuant to the procedures established by the Board of Trustees or by one or more Benefit Providers, as the case may be, and described in the Program Document. You must submit claims for benefits in accordance the terms of the Program.

4.03 Limitations on Legal Actions

No legal action concerning a denial of benefits under the Plan may be commenced against the Plan, the Board of Trustees, or any representative of the Plan until the claimant has exhausted all of the administrative remedies set forth under the claims procedures for the applicable Program.

Any suit or legal action initiated by a person for benefits under a Program must be brought no later than two years following a final decision on the appeal of the claim for benefits by the person or entity described herein or in the applicable Program Document with the discretionary authority to determine appeals with respect to such claim unless a longer period of time is required under applicable law, in which case, such longer period shall apply. Notwithstanding the foregoing, if a Program provides for a shorter time period for suits or legal action to be brought following a final decision on the appeal of the claim for benefits, such shorter period shall apply instead of the two years period unless a longer period of time is required under applicable law, in which case, such longer period shall apply. In no case may a suit or legal action be brought if the claim for benefits was not made within any time period prescribed in the claims procedures of the applicable Program Document.

4.04 Participant's Responsibilities

Each Participant shall be responsible for providing the Board of Trustees, or is delegee, with the Participant's current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. The Board of Trustees shall not have any obligation or duty to locate a Participant. In the event that a Participant becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

(a) because the current address according to Plan records is incorrect;

(b) because the Participant or Beneficiary fails to respond to the notice sent to the current address according to Plan records;

(c) because of conflicting claims to such payments; or

(d) because of any other reason

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings except to the extent required by law. If, after reasonable efforts, the Board of Trustees is unable to locate any Participant whose benefits under the Plan have become distributable, such benefits may be forfeited in accordance with the terms of the Plan. If the Participant subsequently applies for benefits, the amount so forfeited will be paid. Notwithstanding the forgoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the insurance policy shall control to the extent such terms are inconsistent with this section.

4.05 Fraud or Misrepresentations

Subject to the Board of Trustees' discretion, an individual who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. False or misrepresented information could cause the Participant's coverage to terminate irrevocably and retroactively to the extent permitted by law. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. The Board of Trustees reserves the right to ask for proof of eligibility for a Dependent, and any other information or proof as required by the Plan. Failure on the part of a Participant or Dependent to comply with a request by the Plan, for information or proof within a reasonable period of time is sufficient grounds for delay in the payment of any benefits that may be due under the Plan until such information or proof is received. The Plan may rely on any information furnished by a Participant or Dependent and this information will be conclusively binding upon the Participant or Dependent furnishing the evidence.

4.06 Overpayment

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Board of Trustees or an insurance company, as applicable, may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the Board of Trustees' or insurance company's own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Board of Trustees or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, or (c) any other method as may be required or permitted in the sole discretion of the Board of Trustees or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

4.07 Right of Subrogation and Reimbursement

To the extent the subrogation and reimbursement provisions in this section are different than the subrogation and reimbursement provisions set forth under an applicable Program Document for an insured Program, the terms of that Program will control, except that if such terms of the Program do not comply with applicable law, the subrogation and reimbursement provisions in this section will control.

(a) If the Plan pays benefits to or for any Participant for any injury, illness, expense, or loss, the Plan will be subrogated for the full amount of such payments to all rights of the Participant, or any assignee of the Participant against any person,

firm, corporation or other entity in connection with any claim related to the injury, illness, expense, or loss.

(b) If the Plan pays benefits to or for any Participant for any injury, illness, expense or loss caused, or alleged to be caused, by any person, and the Participant (or someone acting on behalf of the Participant) or any assignee of any of the Participant obtains any recovery from any source in connection with the injury, illness, expense or loss, whether by lawsuit, settlement or otherwise, including any recovery from the Participant's insurance, and regardless of how the recovery is characterized or named, the Plan shall be entitled to full reimbursement from the Participant (or person acting on behalf of the Participant) or any assignee of any of the Participant to the full extent of the Plan's payments.

(c) The Plan's rights of subrogation and reimbursement under (a) and (b) above shall have first priority and shall not be reduced for any reason, including for attorney's fees, the "fund" doctrine, the "common fund" doctrine, comparative or contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's right to subrogation or reimbursement. Likewise, the Plan's right to subrogation or reimbursement shall exist and be enforceable without regard to whether the Participant (or person acting on behalf of the Participant) is "made whole" for his or her loss. Notwithstanding the above, the Board of Trustees or the Board of Trustees' delegee may determine, in the exercise of its sole discretion, to reduce the Plan's recovery in appropriate circumstances, which may include, with respect to attorney's fees, a condition that the attorney representing the Participant or assignee has agreed in advance to honor the rights of the Plan with respect to subrogation and reimbursement contained herein.

(d) Once a covered person has any reason to believe that he/she may be entitled to recovery from any source, the covered person must notify the Plan. Prior to payment by the Plan to or for a Participant (or someone acting on behalf of the Participant) for any injury, illness, expense, or loss caused, or alleged to have been caused, in circumstances that may support a recovery from any person, the Participant (or someone acting on behalf of the Participant) will be asked to execute a subrogation and reimbursement agreement consistent with the terms of this section. Failure to request or obtain such an agreement prior to the payment by the Plan shall not in any way diminish the Plan's rights of subrogation and reimbursement herein. If a covered person fails or refuses to execute the required subrogation or reimbursement agreement, the Plan may deny payment of any benefits to the covered person until the agreement is signed. Alternatively, if a covered person fails or refuses to execute the required subrogation or reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the covered person, the covered person's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement, and the covered person's agreement to a constructive trust, lien and/or equitable lien by

agreement in favor of the Plan on any payment, amount or recovery that the covered person recovers from any source.

(e) By participating in the Plan, each covered person consents and agrees that, once Plan benefits are paid, a constructive trust, lien, or an equitable lien by agreement in favor of the Plan exists with regard to any payment, settlement, or recovery relating to an injury, illness, expense, or loss for which the Plan has provided benefits. In accordance with that constructive trust, lien, or equitable lien by agreement, each covered person agrees to cooperate with the Plan by reimbursing it for Plan benefits received.

(f) The Participant shall do nothing to prejudice the Plan's rights under this section and shall promptly inform the Plan of the name and address of any attorney representing the Participant or assignee. The Participant shall assist the Plan upon request, including instituting legal proceedings against any appropriate persons, firms, corporations, or entities.

(g) In the event that the Plan is not fully reimbursed as set out in this section, the Plan shall have the right, as the Board of Trustees or the Board of Trustees' delegee may determine, in the exercise of its sole discretion, to reduce any future benefits to which the Participant or assignee is or may become entitled, by the amount not reimbursed or recovered by the Plan.

ARTICLE 5
ADMINISTRATIVE AND FIDUCIARY PROVISIONS

5.01 Fiduciary

Except as may otherwise be provided in the Appendix with respect to any particular Program, the Board of Trustees is responsible for administration of the Plan. The Board of Trustees, however, may delegate in writing any of its powers or duties under the Plan to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Board and any references to the Board of Trustees shall instead apply to the delegee.

5.02 Discretionary Authority

The Board of Trustees, or, where applicable, its authorized delegee, shall have the exclusive authority, in its sole and absolute discretion, to administer and interpret the Plan, to establish rules governing the operation of the Plan and the transaction of its business, to decide all matters arising in connection with the operation or administration of the Plan, and to take such actions as are described in Article 5 of Plan. The determination of the Board, or its authorized delegee, as to any disputed question shall be conclusive. Subject to the requirements of the law, the Board of Trustees, or its authorized delegee, shall be the sole judge of the standard of proof required in any case and the application and interpretation of this booklet, and the decisions of the Board of Trustees shall be final and binding on all parties. Furthermore, benefits under this Plan will be

paid only if the Board of Trustees, or its authorized delegee, decides in its discretion that the applicant is entitled to them under the terms of the Plan. Accordingly, it is intended that any review of an exercise of discretionary authority by the Board of Trustees, or its authorized delegee, by a court or an arbitrator is to be limited to whether the decision of the Board of Trustees, or its authorized delegee, was a clear abuse of its discretion.

5.03 Powers and Duties of the Board of Trustees

The Board of Trustees shall have full authority to administer, operate, and interpret the Plan, including, without limitation, as follows:

(a) The Board of Trustees will administer the Plan in accordance with its terms.

(b) The Board of Trustees is hereby provided with all powers necessary to carry out the Plan's provisions including, without limitation, the right to employ a third-party administrator or a collection agent and the right to seek to enforce (through court process or other means available under applicable law) all rights of the Plan (including, without limitation, all rights the Plan may have to recover benefits paid or payable to Participants from any other source).

(c) The Board of Trustees is empowered to determine questions arising in the administration, interpretation, and operation of the Plan and, in so doing, may consult with, and rely upon, such legal, accounting, actuarial, financial, insurance, or medical consultants as it deems necessary or proper.

(d) The Board of Trustees has the authority to delegate its powers under this Section 5.03 to others, including, without limitation, to a Benefits Provider, provided that such other third party shall have agreed to exercise such powers.

(e) The Board of Trustees will keep (or shall cause to be kept) such records of its proceedings and decisions and shall keep all such books of account, records, and data as may be necessary, in its judgment, for the proper administration of the Plan.

(f) The Board of Trustees may prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan.

(g) The Board of Trustees may prepare and distribute information explaining the Plan to Participants.

(h) The Board of Trustees is empowered to require the Employer, Participants, and Dependents to provide such information as shall be necessary for the proper administration of the Plan.

(i) The Board of Trustees may appoint individuals, committees, or service providers to assist in the administration of the Plan and to engage any other agents it deems advisable.

(j) The Board of Trustees may purchase any insurance deemed necessary for providing benefits under the Plan.

(k) The Board of Trustees may accept, modify, or reject Participant elections under the Plan.

(l) The Board of Trustees may promulgate election forms and claim forms to be used by Participants.

(m) The Board of Trustees may prepare and file any reports or returns with respect to the Plan required by the Code or any other laws.

(n) The Board of Trustees may determine and enforce any limits on benefits elected hereunder.

(o) The Board of Trustees may correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant in whatever manner the Board determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

(p) The Board of Trustees may issue rules and regulations necessary for the proper conduct and administration of the Plan and to change, alter, or amend such rules and regulations.

(q) The Board of Trustees may propose and accept settlements of claims involving the Plan, other than claims for insured benefits, which responsibility is retained by the insurance company.

(r) The Board of Trustees may exercise such other duties or powers provided in the Plan.

5.04 Facility of Payments

If the Board of Trustees finds that any person to whom an amount is payable under the Plan is unable to care for his or her affairs because of physical or mental illness or accident, or is a minor, or has died, then any payment due him or her, or his or her estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to his or her spouse, a child (in accordance with the Uniform Gifts to Minors Act or State “gifts to minors” act, if applicable), a relative, an institution maintaining or having custody of such person, or any other person deemed by the Board of Trustees to be a proper recipient on behalf of such person otherwise entitled to

payment. Any such payment shall constitute a complete discharge of the liability of the Plan and the Board of Trustees.

ARTICLE 6
GENERAL PROVISIONS

6.01 Benefits Not Transferable

Except as required by applicable law, benefit payments hereunder shall not in any way be subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, anticipated, alienated, encumbered, pledged, transferred or assigned.

6.02 Compliance With Legal Requirements

In addition to the powers of the Board of Trustees expressly set forth herein, the Board of Trustees shall have the power and authority to take any action required to cause the Plan and the Fund to be in compliance with applicable provisions of law.

6.03 Factual Determinations

Any misstatement or other mistake of fact in any certificate, notice, or other document filed with or issued by the Board shall be corrected when it becomes known. The Board of Trustees shall not be liable in any manner for any determination of fact made in good faith.

6.04 Proof of Claims

As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Board of Trustees may require either directly to the Board of Trustees or to any person delegated by it. Failure on the part of a claimant to comply with such request promptly, accurately, and in good faith shall be sufficient grounds for denying, postponing, or discontinuing benefits from the Plan to such person.

6.05 Title to Trust

Except with respect to the right to receive benefits for which a Participant qualifies under the Plan, no individual shall have any right, title, or interest in and to the assets of the Fund or to the contributions thereto, such contributions being made and held in the Fund for the sole purpose of providing benefits under the Plan in accordance with its terms. The Board of Trustees does not in any way guarantee the Fund from any loss or depreciation, or guarantee payment of any benefit which may become due to any person under the Plan. The Plan's obligation to pay benefits is conditioned on the availability of cash in the Fund and no plan fiduciary or other person shall be required to liquidate any asset of the Fund to generate cash to pay benefits. Further, the liability for payment of Benefits under a Program described in the Appendix of this booklet as of any date is limited solely to the terms of such Program and, where applicable, the Benefit Provider's obligation pursuant to such Program.

6.06 Limitation of Rights

Neither the establishment nor the existence of the Plan nor any modification thereof shall operate or be construed so as to:

(a) give any person any legal or equitable right against the Plan, Board of Trustees, Employer, or Union, except as expressly provided herein or required by law; or

(b) create a contract of employment with any Employee, obligate the Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

6.07 Expenses

All fees and expenses incurred in connection with the operation and administration of the Plan, including, without limitation, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of any Plan asset to the extent that it is legally permissible for these fees and expenses to be so paid.

6.08 Interpretation

In the event that the provisions of any Program conflicts with or contradicts the provisions of this document or any other Program, the Board of Trustees shall use its discretion to interpret the terms and purpose of the Plan so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant to benefits available under any Program.

6.09 Right of Recovery

The Board of Trustees shall have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment.

6.10 Usage

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural, and vice versa.

6.11 Governing Law

Except to the extent that state law is preempted by federal law, the Plan shall be administered and construed to be in accordance with the laws of the State of New York.

6.12 References to the Internal Revenue Code

Any reference to a section of the Internal Revenue Code shall include a reference to any successor provision of the Internal Revenue Code.

6.13 No Contract

Neither the Plan nor any portion thereof shall be deemed to constitute a contract between the Board of Trustees and any Participant.

ARTICLE 7
CONTINUATION COVERAGE

7.01 Continuation Coverage

A Participant or Beneficiary may continue coverage for benefits under the Plan as described in the applicable Program Document.

ARTICLE 8
AMENDMENT AND TERMINATION

8.01 Amendment

The Plan, including any Programs maintained pursuant to the Plan with respect to any group of Participants, may be amended by ATU Local 726, by written instrument, at any time and from time to time in its sole and absolute discretion.

8.02 Termination

The Plan, including any Programs maintained pursuant to the Plan with respect to any groups of Participants, may be terminated at any time by ATU Local 726, by written instrument, in its sole and absolute discretion.

8.03 No Reversion or Inurement

Under no circumstances may any assets of the Fund revert or inure to the benefit of the Employer, Union, Board of Trustees, or their respective successors.

ARTICLE 9
MISCELLANEOUS

9.01 Board of Trustees

The Board of Trustees, as originally constituted, consists of the following three individuals:

Daniel Cassella
Thomas Carney
Thomas Mason

The Board of Trustees may be reached at:

ATU Local 726 Benefits Fund
c/o Extensive Benefits, Inc.
P.O. Box 813546
Smyrna, Georgia 30081

3948 Amboy Road
Staten Island, NY 10308
718-967-8930

9.02 Service of Legal Process

Legal process may be served on the Board of Trustees at the addresses set forth in Section 9.01.

Addendum – Privacy Notice

ATU Local 726 Benefits Fund
c/o Extensive Benefits, Inc.
P.O. Box 813546
Smyrna, Georgia 30081

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Please note that the information that the Plan has on file pertains only to your enrollment and eligibility to receive benefits from the Plan.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Please note that the information that the Plan has on file pertains only to your enrollment and eligibility to receive benefits from the Plan.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1 of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive.
As noted above, the Plan has information that pertains only to your enrollment and eligibility to receive benefits from the Plan.

If applicable, we could use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

If applicable, we could use and disclose your health information as we pay for your health services.

Example: We share information about you to coordinate payment for your medical expenses.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Certain statistics could be provided to evaluate the benefits provided by the Plan.

How else can we use or share your health information?

As noted above, the Plan has information that pertains only to your enrollment and eligibility to receive benefits from the Plan. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and we will mail a copy to you.

Effective Date of this Notice – April 1, 2015

Privacy Official
ATU Local 726 Benefits Plan
Extensive Benefits, Inc.
P.O. Box 813546
Smyrna, Georgia 30081

Addendum – COBRA General Notice

General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Extensive Benefits, Inc., P.O. Box 813546, Smyrna, Georgia 30081.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying

events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

Keep your Plan informed of address changes

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

Plan contact information

ATU Local 726 Benefits Plan
Extensive Benefits, Inc.
P.O. Box 813546
Smyrna, Georgia 30081
Email: Info@extensivebenefits.com
Phone: 1-888-416-4211
Fax: 1-404-585-3508

Appendix A

Programs Offered Under the Plan

The following Programs shall be incorporated by reference into and made a part of this Plan as of April 1, 2015 or the Program's effective date, if later:

Benefits	**The Claims Administrator for the Benefit**
Vision Please see Appendix B, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's vision benefits. A short description of the vision benefits follows the "Other Information about the Plan" section.	General Vision Services (GVS) 520 Eighth Avenue Suite 901 New York, NY 10018 855-653-0586 www.generalvision.com
Dental – Dentcare Please see Appendix C, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's Dentcare dental benefits. A short description of the Dentcare dental benefits follows the "Other Information about the Plan" section.	Dentcare Delivery Systems, Inc. 333 Earle Ovington Blvd., Suite 300 Uniondale, NY 11553-3608 800-468-0600 www.healthplex.com
Dental – CIGNA P2X00 (Low) Please see Appendix D, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's CIGNA P2XOO (low) dental benefits. A short description of the CIGNA dental benefits follows the "Other Information about the Plan" section.	CIGNA 140 East 45th Street New York, NY 10017 800-CIGNA24 (800-244-6224) www.cigna.com
Dental – CIGNA P1-00 (High) Please see Appendix E, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's CIGNA P1-00 (high) dental benefits. A short description of the CIGNA dental benefits follows the "Other Information about the Plan" section.	CIGNA 140 East 45th Street New York, NY 10017 800-CIGNA24 (800-244-6224) www.cigna.com
Life Insurance Please see Appendix F, which is available on-line at www.ATU726benefitsfund.com, for more detailed information about the Plan's Aetna life insurance benefits. A short description of the life insurance benefits follows the "Other Information about the Plan" section.	Aetna Life Insurance Company PO Box 14549 Lexington, KY 40512-4549 800-523-5065 800-238-6239 (fax) www.aetna.com

Appendix B – Vision – General Vision Services (GVS)

- available on-line at www.ATU726benefitsfund.com

Appendix C – Dental – Dentcare

- available on-line at www.ATU726benefitsfund.com

Appendix D – Dental – CIGNA P2X00 (Low)

- available on-line at www.ATU726benefitsfund.com

Appendix E – Dental – CIGNA P1-00 (High)

- available on-line at www.ATU726benefitsfund.com

Appendix F – Life Insurance – Aetna

- available on-line at www.ATU726benefitsfund.com