

SUMMARY PLAN DESCRIPTION

**Labor-Management Healthcare Fund
Dental Plan**

January 1, 2017

Plan Information

Plan Name: The Labor-Management Healthcare Fund
Dental Plan

Plan Sponsor/Plan Administrator Name, Address and Phone Number: Board of Trustees
Labor-Management Healthcare Fund
3786 Broadway
Cheektowaga, NY 14227
(716) 601-7980

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Employer ID #: 20-0422657

Plan Year: January 1 to December 31

Agent for Service of Legal Process: Board of Trustees
Labor-Management Healthcare Fund
(address and phone above)

Plan Changes or Termination: The Plan Administrator may terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

Accompanying Documents: **SPD** – This document, together with the attached Emblem Health Summary of Benefits and Certificate of Insurance (the “Attachments”), constitutes your Summary Plan Description (“SPD”). If the terms of this summary document conflict with the terms of the Attachments, the terms of the Attachments will control, unless superseded by applicable law.

Benefit Information

Plan Name: Labor-Management Dental Plan

Type of Plan Benefit: Self-insured dental benefit

Contract Administrator: Group Health Incorporated
Responsible for processing of dental claims 441 Ninth Avenue
New York, NY 10001-1681

I Introduction

This document is called a “Summary Plan Description”. Its purpose is to explain the provisions of your Employer’s self-funded group dental plan, as provided through the Labor-Management Healthcare Fund (the “Fund”). You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions.

The Plan is comprised of self-insured benefits. Your dental benefits are paid directly from the Fund, a trust entity that administers these benefits.

Your dental benefits are provided through an administrative services agreement between the Fund and Group Health Incorporated (“GHI”). The Certificate of Insurance and Plan Summary (the “Attachments”) describe your dental benefits in detail.

If you have any questions about your benefits under the Plan, please contact your Employer.

II Funding Medium and Type of Plan Administration

The Plan is maintained pursuant to a collective bargaining agreement between your Employer and your Union. Your Employer contributes to the Fund on your behalf. If you are required to contribute toward the cost of coverage, this will be done through your individual Employer as well.

Your dental benefits are self-insured by your Employer through the Labor-Management Healthcare Fund. Claims for benefits are sent to the Claims Administrator, GHI. GHI (not your Employer or the Fund) is responsible for paying these claims.

III Claims Administrator Information

If you need additional information regarding your dental benefits, you should contact GHI at the following address and telephone numbers:

GHI:

Customer Service:
1-800-624-2414

Claims Mailing Address:
P.O. Box 3000, New York, NY 10116-3000

IV Eligibility and Participation

Eligibility for participation in the Plan is determined according to rules adopted by your individual Employer in accordance with your collective bargaining agreement. You should contact your Employer to see if you are in a job classification eligible for coverage under this Plan.

Your Certificate of Insurance sets forth the eligibility rules for your spouse and children. The Plan Administrator will also use these rules to determine eligibility for your spouse and children for dental benefits.

V Enrollment – Effective Date of Coverage

You must complete an application form (available through your Employer) to enroll yourself and/or your eligible spouse and dependents. Coverage under the Plan will be effective on the date you, your spouse and your dependents become eligible provided you “timely enroll.”

The enrollment will be “timely” if the completed form is received by your Employer no later than 31 days after the person becomes eligible for the coverage. Otherwise, coverage will become effective with the next January 1 open enrollment following your application.

In certain circumstances, enrollment may occur outside the open enrollment period. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other dental insurance or coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

VI Termination of Coverage

In general, your coverage under this Plan terminates on the last day of the month in which you terminate employment with your Employer. Coverage under the Plan may terminate earlier if

you fail to pay your share of the premiums, if your hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the Attachments.

Coverage for your covered family members stops when your coverage stops. Coverage for a family member will also stop if that family member becomes ineligible (for example, due to divorce or a dependent's attaining the age limit specified) or for other reasons specified in the Attachments (such as nonpayment of applicable premiums). It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, etc., and to update previously provided information and statements. Failure to do so may be considered an intentional misrepresentation of material fact, and may result in termination of coverage; such termination may be retroactive.

Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

VII Dental Benefits

Your Employer provides dental coverage through the Fund on a self-insured basis. The exact benefits are as described in the Attachments. These Attachments will control as to those persons who will be eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to be covered (if any), and the benefits and circumstances under which coverage terminates, if different from this Summary Plan Description.

VIII Coordination of Benefits

The coordination of benefits sets out rules for the order of payment of medical benefits when two or more plans—including Medicare—are paying. If you are covered by this Plan and another plan, or your spouse is covered by this Plan and by another plan, or your dependent children are covered by two or more plans, the plans will coordinate benefits when a claim is received. The rules for determining which plan pays first are set forth in the Certificate of Insurance. The Plan Sponsor will also use these rules for determining which plan will pay dental benefits.

IX Family and Medical Leave Act

If the Family Medical Leave Act (FLMA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the

right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled “Continuation Coverage (COBRA).”

X Qualified Medical Child Support Orders

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order.

XI Continuation Coverage

COBRA continuation coverage allows you and your dependents an opportunity to temporarily extend your dental coverage under the Plan at group rates in certain instances where coverage would otherwise end.

Eligibility. You or your dependents that are eligible to purchase continuation coverage are “qualified beneficiaries”. If a child is born to or adopted by or placed for adoption with an employee during a period of COBRA continuation coverage, the newborn or newly adopted child’s maximum continuation period shall be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle you or your dependents (as qualified beneficiaries) to continuation coverage are “qualifying events”. The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;

- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.

Maximum Period of Continuation Coverage. The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Notice Requirements. A qualified beneficiary must inform your Employer of a divorce or legal separation, or of a child losing dependent status under the plan, within sixty (60) days after the later of the date of the qualifying event or the date the qualified beneficiary loses dental coverage on account of that qualifying event. If timely notice is received, the Employer has the responsibility to notify the Fund of the divorce, legal separation or loss of dependent status. Your employer also has the responsibility to notify the Fund of your death, termination of employment, reduction in hours, or Medicare entitlement.

Your Employer will notify all eligible qualified beneficiaries of their right to elect continuation coverage. If a qualified beneficiary chooses to purchase continuation coverage, the qualified

beneficiary must notify your employer in writing within sixty (60) days after the later of: the date the qualified beneficiary loses health coverage on account of the qualifying event or the date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage. If the qualified beneficiary does not choose continuation coverage during the sixty (60) day period, his or her participation will end as otherwise provided in the Plan Booklet.

Coverage. If a qualifying event occurs, you and your dependents who are qualified beneficiaries must be offered the opportunity to elect to receive the group dental coverage that is provided to similarly-situated nonqualified beneficiaries. Generally, this means that if you or your dependents purchase continuation coverage, it will be the same as the dental coverage provided to you immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to you and your dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during an annual open enrollment period in accordance with the opportunity to provide similarly-situated active employees.

Cost. Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries who elect an additional eleven (11) months of continuation coverage, the cost may be 150% of the cost of identical coverage for similarly-situated participants for the additional eleven (11) month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law). The 150% cost amount shall also apply to the disabled qualified beneficiary's dependents, as long as the disabled qualified beneficiary is in the coverage group receiving COBRA.

The initial premium must be paid within forty-five (45) days after the qualified beneficiary elects continuation coverage. Subsequent premium must be paid monthly, as of the first day of the month, with a thirty (30) day grace period for timely payment. However, no subsequent premium will be due within forty-five (45) days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

Termination. Generally, continuation coverage terminates at the end of the 18, 29 or 36-month continuation period, as applicable. However, continuation coverage for a qualified beneficiary may end before the end of the continuation period for any of the following reasons:

- **Coverage Terminated**
Employer no longer offers a group dental plan to any of its employees;
- **Unpaid Premium**
The premium for continuation coverage is not timely paid;

- **Other Coverage**

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group dental plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or exclusion which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to the Health Insurance Portability and Accountability Act;

- **Medicare**

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or

- **Cause**

The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

XII Claims Procedure – Rescission of Coverage

A Rescission of Coverage is a cancellation or discontinuance of medical coverage that is effective **retroactively** and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a Rescission of Coverage. If you are notified by your Employer or the Plan Administrator or their delegate that your coverage under the Plan is being rescinded, that notification is considered to be a claim denial. You may appeal a Rescission of Coverage within 180 days after your receipt of the notice of Rescission of Coverage. Your appeal will be considered within 60 days after the Plan Administrator receives your appeal, with a 60-day extension permitted if necessary.

Please submit your appeal to the following address:

Labor-Management Healthcare Fund
Attn: Vicki Martino, Executive Director
3786 Broadway
Cheektowaga, NY 14227
(716) 601-7980

XIII Claims Procedure

GHI is responsible for evaluating all benefit claims under the Plan. GHI will decide your claim in accordance with its reasonable claims procedures, as set forth in the Certificate of Insurance. If your claim is denied, you may appeal to GHI for a review of the denied claim and GHI will decide your appeal in accordance with its procedures. See the Certificate of Insurance for complete details regarding GHI's claims and appeals procedures.

XIV THIRD-PARTY RECOVERY PROVISION

Right Of Subrogation And Refund

When this provision applies. You or a covered dependent (a “Covered Person”) may incur medical charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan’s right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person’s Third Party Claims.

Notwithstanding its priority to funds, the Plan’s Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys’ fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan’s right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover", "Recovered", "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

XVII COMPLIANCE WITH HIPAA PRIVACY STANDARDS.

Certain members of the Fund's workforce perform services in connection with administration of

the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the “Privacy Standards”), these Employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Fund’s workforce unless each of the conditions set out in this HIPAA Privacy section is met. “Protected Health Information” shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Fund’s workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan’s administrative functions shall include all Plan payment and health care operations. The terms “payment” and “health care operations” shall have the same definitions as set out in the Privacy Standards, but the term “payment” generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. “Health care operations” generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Fund’s workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, “members of the Fund’s workforce” shall refer to all Employees and other persons under the control of the Plan Administrator.
 - (a) **Updates Required.** The Plan Administrator shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Fund’s workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Fund's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

- (4) **Certification of Plan Administrator.** The Plan Administrator must provide certification to the Plan that it agrees to:
 - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Fund with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Fund;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any

accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Fund still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of each Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

HIPAA NOTIFICATION

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Privacy Notice, which has been distributed to each Employee covered under the health plan.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If a Covered Person has a complaint, questions, concerns or requires a copy of the Privacy Notice, please contact the Privacy Official in the Plan Administrator's office.

XVIII Amendment and Termination

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a collective bargaining agreement remaining in effect that provides for continued Employer contributions to the Fund. Therefore, the Trustees reserve the right to amend or terminate the Plan, in whole or in part, at any time.