AGMA

HEALTH FUND REIMBURSEMENT PLAN

Summary Plan Description

April 2024

AGMA HEALTH FUND
REIMBURSEMENT PLAN
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AGMA HEALTH FUND
REIMBURSEMENT PLAN

April 1, 2024

Dear Participant:

We are pleased to provide you with this booklet effective April 1, 2024, which describes how you can use your Individual Account in the AGMA Health Fund Reimbursement Plan (formerly known as Plan B) for your health care needs and those of your dependents. The rules described in this Summary Plan Description apply to claims incurred in the period on and after September 1, 2021, subject to the Rules set forth in Section 7 below.

This booklet replaces and supersedes prior materials distributed to you describing your Individual Account in the AGMA Health Fund Reimbursement Plan.

Please note that you can use your Individual Account toward the reimbursement of an extensive list of medical expenses that are not covered by a health policy or plan, or for the premiums or costs of other health plan coverage that you may have, except for premiums for individual health policies and member cost-sharing incurred under individual policies, subject to the rules set forth in this booklet.

We urge you to read this booklet carefully so that you will be fully aware of the conditions for eligibility and reimbursement and the benefits to which you may be entitled. We also urge you to share the booklet with your family. Keep this booklet in a safe place. If you lose it, you may request another copy from the Fund Office. We believe this Plan has the flexibility to meet some of the health care needs of all Artists and their dependents.

Sincerely,

THE BOARD OF TRUSTEES

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1. OVERVIEW

Collective bargaining agreements between AGMA and certain opera, ballet and concert companies ("Contributors") require contributions on behalf of the Artists they engage to help cover the cost of health coverage and medical benefits. The contribution rate is set by collective bargaining agreements. A complete list of current Contributors is available upon request from the Third-Party Administrator.

This Plan, now called the AGMA Health Fund Reimbursement Plan ("Reimbursement Plan" or "Plan") (formerly known as Plan B), was established by the Board of Trustees of the AGMA Health Fund to receive such contributions on behalf of participating Artists. The Reimbursement Plan is intended to serve as a source of funds that Participants can use to get reimbursed for the cost of some health coverage and to the reimbursement of certain medical expenses that are not otherwise covered by a health policy or plan. In view of the various engagement patterns of Artists, the Reimbursement Plan is structured for the maintenance of Individual Accounts where contributions are available for reimbursement of a broad range of eligible medical expenses.

Briefly, the Individual Accounts <u>are available</u> to help defray Participants' premiums[1] and medical expenses as follows:

- Payments required for a Participant's coverage under the AGMA Health Fund Standard Plan, for those who are eligible for and elect such coverage pursuant to Section 5.A.1 below;
- Required participant contributions for AGMA Health Fund Standard Plan coverage, unless payment for such contributions has already been made on a pre-tax basis (through payroll deduction or otherwise);
- Payments required to cover a Participant's spouse and/or dependents under the AGMA Health Fund Standard or Healthy Savings Plans (formerly known as Plan A and Plan A1, respectively), unless such payments have already been made on a pre-tax basis (through payroll deduction or otherwise);
- Premiums for any other group health policy or plan that covers the Participant, either directly or as a dependent (including premiums for coverage of the Participant's dependents in addition to the Participant);
- Premiums for group health coverage for Participants' dependents can be reimbursed from Plan balances accrued on and after September 1, 2014 even if the Participant is not included in the coverage, subject to other Plan rules;
- Medical expenses not covered by a health policy or plan when incurred by Participants and their dependents, except member cost-sharing incurred under individual policies. (Types of expenses covered include deductibles, co-payments, dental, optical, substance abuse programs and other benefits for which a complete listing appears in a later section of this booklet.); and
- Medicare premiums and cost sharing incurred by the Participant, subject to certain limitations described below.

The Individual Accounts <u>may not</u>, however, be used for:

- The cost of premiums for individual health policies (including plans purchased through an ACA Marketplace);
- Cost-sharing (i.e., copayments, deductibles, coinsurance, etc.) incurred under individual policies; or
- Costs that have been paid on a pre-tax basis, through payroll deduction or otherwise.
    - For example, if your required participant contribution for AGMA Health Fund Standard Plan coverage has been paid by your employer pursuant to a payroll deduction (or otherwise), your Individual Account may not be used to reimburse or otherwise cover the cost of that contribution.
    - For another example, if your employer has paid for the cost of coverage under the AGMA Health Fund Standard Plan for your spouse and/or dependents, your Individual Account may not be used to reimburse or otherwise cover that cost.

If you have any questions regarding the contents of this Summary Plan Description, or about the Reimbursement Plan generally, please contact the Third-Party Administrator named in Section 3.

[1] As used in this Summary Plan Description, "premiums" include payments required to obtain coverage under a self-insured health plan, except where the context indicates otherwise.

2. DEFINITIONS

Administrative Expenses: Expenses to operate the AGMA Health Fund Reimbursement Plan, including, but not limited to, expenses for the maintenance of Individual Accounts, communications with Participants, professional and service fees and interaction with insurance companies or plans on behalf of Participants, and costs in connection with processing of reimbursement of medical expenses. Allocation of these expenses to Individual Accounts is detailed in Section 9.B.

Artist - An Artist as defined by collective bargaining agreements between AGMA and Contributors, as well as any individual covered by a participation agreement with the Fund for whom in each case Contributors are required to make contributions to the AGMA Health Fund Reimbursement Plan for work in Covered Employment.

Contributors/Employers: A contributing company or organization which is a signatory to a collective bargaining agreement with the Union or participation agreement with the Fund requiring contributions to the AGMA Health Fund Reimbursement Plan on behalf of Artists.

Covered Engagement/Covered Employment: Engagement as an Artist by a Contributor.

Fund: The assets of the AGMA Health Fund Reimbursement Plan.

Individual Account: The accumulation of Contributor contributions on behalf of an Artist as increased and/or decreased and as otherwise maintained pursuant to Section 9 below. The amount in each Individual Account as of the most recent Valuation Date is detailed in Section 9.A.

Investment Return: The yield of the invested assets of the AGMA Health Fund Reimbursement Plan. Investment Return is attributed to Individual Accounts in accordance with Section 9.C.

Participant: An Artist with an Individual Account balance.

Union: American Guild of Musical Artists (AGMA)

Valuation Dates: Last calendar day of February, May, August and November of each year.

Valuation Period: March 1 through May 31, or June 1 through August 31, or September 1 through November 30, or December 1 through the last date in February (i.e., February 28 or 29).

3. THE ROLE OF THE REIMBURSEMENT PLAN TRUSTEES AND THE THIRD-PARTY ADMINISTRATOR

The Board of Trustees is the named Plan Administrator of the Reimbursement Plan. The Board of Trustees has engaged the services of Administrative Services Only, Inc. ("Third-Party Administrator") to perform many of the administrative functions outlined in this Summary Plan Description, including but not limited to: the payment of AGMA Health Fund Standard Plan premiums and the reimbursement of claims for uninsured medical expenses and premiums for other health coverage, the collection and verification of contributions for Participants, communication with Participants about their Individual Account balances and how they can be applied to their health service needs, and the maintenance of Individual Accounts for Participants.

The Third-Party Administrator will also make initial claims decisions, provide you with Individual Account balance information, and provide you with general information regarding the Reimbursement Plan. Therefore, you may obtain claims forms from, and should submit all your claims for reimbursement to, the Third-Party Administrator at:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, New York 11563-9010
Toll Free 1-866-263-1185 www.asonet.com

You may also contact the Third-Party Administrator with general questions about the Reimbursement Plan. The service contract between the Third-Party Administrator and the Board of Trustees is on file at the Fund Office. The Third-Party Administrator is a fiduciary for many of the functions it performs (see Section 16.A outlining your rights under the Employee Retirement Income Security Act of 1974 ("ERISA")).

For Participants who seek reimbursement for outside health coverage premiums (i.e., premiums for coverage other than that provided through the AGMA Health Fund Standard or Healthy Savings Plans) or medical expenses, the Third-Party Administrator must collect from the Participant valid documentation of the expense to be reimbursed. This will include collecting from the Participant proof that the outside health coverage premium or medical expense was paid by the Participant or, if applicable, by the Participant's spouse. Furthermore, the Third-Party Administrator must obtain a bona fide bill paid by the Participant (or his/her surviving covered dependent pursuant to Sections 5.B.1.b. and 8 below) from a medical provider for the reimbursement of uninsured medical expenses.

4. ELIGIBILITY AND PARTICIPATION

Artists as defined in Section 2 will have an Individual Account set up on their behalf upon the receipt of contributions. An Artist, or his/her eligible dependents, may participate in the Plan when the Artist has funds in an Individual Account.

The Reimbursement Plan is available to Participants and their eligible dependents up to the amount currently in the Participant's Individual Account, subject to the other provisions set forth herein. Please note, however, that individuals who elect the AGMA Health Fund Healthy Savings Plan, which is a High-Deductible Health Plan ("HDHP") paired with a Health Savings Account ("HSA"), must, as part of that election, also elect to suspend access to their Reimbursement Plan balances during the period when HSA contributions are being made on their behalf under the Healthy Savings Plan, except that they may still use their Reimbursement Plan balances for the following types of expenses incurred during such period (subject to the other rules set forth herein): dental care, vision care, preventive care, and HDHP premiums paid with post-tax funds (i.e., not through payroll deduction) under the Healthy Savings Plan.

Your Eligible Dependents are:

- your legal spouse;
- your dependent children to the last day of the month in which they reach age 26;
- your unmarried dependent children who are over the age of 26 and unable to support themselves because of mental illness, developmental disability, mental retardation (all as defined in the New York mental hygiene law) or physical handicap, provided the incapacitating condition started and initial proof of the condition is submitted to the Fund Office before the child reaches age 26, when coverage would otherwise end. The finding of such disability shall be made by a physician, the Social Security Administration or other governmental agency, a court, or another benefit plan. Proof of the initial finding and of continued disability (as found by any of the entities referenced in the previous sentence) must be submitted annually. The Plan will not make any finding of disability.

  Dependent children include your biological children, your adopted children or children placed with you for adoption, your stepchildren, and any other children for whom a court has awarded you legal custody or guardianship.

You may also cover as your dependent a person who is your "Domestic Partner" as defined below.

➢ Definition of Domestic Partner

The AGMA Health Fund Reimbursement Plan defines domestic partners as follows:

Two unmarried adults (both of whom are 18 years or older) of the same or opposite sex, neither of whom is married or legally separated who:

- have resided with each other for six months prior to the application for benefits and who intend to live continuously with each other indefinitely;
- are not related by blood closer than the law would permit by marriage;
- are financially dependent on each other;
- have an exclusive close and committed relationship with each other; and
- have not terminated the domestic partnership.

➢ Procedures for Verifying Domestic Partner Status

A participant who seeks domestic partner coverage will be required to submit:

1) An affidavit form attesting to the domestic partner status;
2) A declaration of financial interdependence; and
3) Copies of two items of proof of financial interdependence (listed below).

A sample affidavit and declaration form are available from the Third-Party Administrator (Administrative Services Only, Inc.) upon request or can be found on its website under “forms”.

The following are acceptable as proof of financial interdependence, provided they are currently in effect or, as to account statements and bills, cover the six-month period prior to the application date:

JOINT BANK ACCOUNT
- Statement with both names
- Check with both names
- Passbook with both names

JOINT CREDIT CARD
- Statement with both names

JOINT OBLIGORS ON LOAN
- Note or other loan origination document with both names

JOINT OWNERSHIP OF RESIDENCE
- Deed or other sale/transfer document with both names
- Property or water tax document with both names

JOINT TENANTS ON LEASE
- Lease with both names

COMMON HOUSEHOLD EXPENSES
- Utility/telephone bill with both names
- Public assistance document with both names

JOINT VEHICLE OWNERSHIP
- Title in both names

JOINT WILLS
- Copy of will or wills, with each party naming the other as beneficiary and/or executor

POWER OF ATTORNEY
- Copy of Powers of Attorney with each party naming the other party and no limitation on the term of the documents

HEALTH CARE PROXY
- Copy of health care proxies/living wills, with each party giving the other party the power to make health care/non-resuscitation decisions up incapacitation

LIFE INSURANCE
- Copy of policy with one party naming the other as beneficiary

RETIREMENT BENEFITS
- Copy of beneficiary designation form with one party designating the other as beneficiary

Persons who fraudulently, wrongfully (or negligently) obtain coverage for persons who are not entitled to such coverage, or who fail to timely notify the AGMA Fund Office of a change in status (such as a divorce or termination of a domestic partnership) that would cause an individual to lose the right to Fund benefits, may be subject to civil action. The Trustees also have the authority to recover the amount of any overpayment (plus interest and costs) and to reduce benefits payable in the future, as described in Section 7.E below.

In addition, those who live in municipalities offering a domestic partner registry (such as New York City and San Francisco) will be required to show proof that they have registered as domestic partners.

Taxation

Reimbursement for a domestic partner’s medical expenses is taxable as wages unless the Participant’s domestic partner is financially dependent on the Participant.

a.) Financially Dependent Domestic Partners

If the Participant presents proof satisfactory to the Trustees that his or her domestic partner is a financial dependent within the meaning of Section 152 of the Internal Revenue Code, health benefits to such partners are not taxable. Adequate proof shall ordinarily mean copies of tax returns showing the partner as a financial dependent and a supporting

affidavit.

b) Non-Dependent Domestic Partners

Except as provided above for financially dependent domestic partners, health coverage paid by the Employer for a participant's domestic partner is taxable as wages of the Participant in the amount of the fair market value of the coverage. Fair market value shall ordinarily mean the amount reimbursed on behalf of the domestic partner. Such amount will be subject to federal and state taxes, including withholding, social security and Medicare (FICA), and unemployment (FUTA).

For Participants participating in the Reimbursement Plan Medical Reimbursement Program, the taxable amount shall be the amount paid for reimbursable expenses of the domestic partner. Taxes shall be deducted before reimbursement for such expenses is paid.

Please note that the tax treatment for this coverage may be different under certain state tax laws. Please contact the Fund Office for further information.

Modification and Interpretation

The Trustees reserve the right to amend or modify the eligibility requirements for domestic partner coverage and to amend, modify or terminate domestic partner coverage at any time for any reason. The Trustees reserve the right to interpret all plan documents concerning domestic partner coverage and to interpret the requirements for and extent of such coverage.

Enrollment of Dependents

You can enroll your dependents for coverage under the Reimbursement Plan at any time, provided you furnish the required proof of dependent status.

5. USE OF YOUR INDIVIDUAL ACCOUNT

Because of the Affordable Care Act ("ACA"), different rules apply to contributions received through August 31, 2014 ("Old Contributions") and contributions received on or after September 1, 2014 ("New Contributions"). The portion of your Individual Account that is attributable to Old Contributions shall be referred to herein as your "Old Plan Balance," and the portion that is attributable to New Contributions shall be referred to herein as your "New ACA Plan Balance." The Old Plan Balance and the New ACA Plan Balance may be jointly referred to as a "Plan Balance." Except as otherwise indicated herein, both Balances can be used for the same kinds of expenses, as described in Section 5.A below. Special rules that apply with respect to your New ACA Plan Balances are described in Section 5.B below.

A. Use of Plan Balances

Your Plan Balances can be used in the following ways:

- to defray the cost of the following:
  - Payments required for a Participant's coverage under the AGMA Health Fund Standard Plan, for those who are eligible for and elect such coverage pursuant to Section 5.A.1 below;
  - Required participant contributions for AGMA Health Fund Standard Plan coverage, unless payment for such contributions has already been made on a pre-tax basis (through payroll deduction or otherwise);
  - Payments required to cover a Participant's spouse and/or dependents under the AGMA Health Fund Standard or Healthy Savings Plans;
- To obtain reimbursement for the cost of the following expenses, if incurred on a post-tax basis (rather than being paid, for example, through pre-tax payroll deduction):
  - Premiums under any other group health policy or plan that covers the Participant, either directly or as a

dependent (including premiums for coverage of the Participant's dependents in addition to the Participant);
- Premiums for group health coverage for Participants' dependents can be reimbursed from Plan Balances accrued on and after September 1, 2014 even if the Participant is not included in the coverage, subject to other Plan rules;
- Medical expenses not covered by insurance when incurred by Participants and their dependents, except member cost-sharing incurred under individual policies. (Types of expenses covered include deductibles, co-payments, dental, optical, substance abuse programs and other benefits for which a complete listing appears in a later section of this booklet.); and
- Medicare premiums and cost sharing incurred by the Participant, subject to certain limitations described below.

Notwithstanding the foregoing, your Plan Balances may not be used for the following:

- The cost of premiums for individual health policies (including plans purchased through an ACA Marketplace);
- Cost-sharing (i.e., copayments, deductibles, coinsurance, etc.) incurred under individual policies; or
- Costs that have been paid by an employer, through payroll deduction or otherwise.
    - For example, if your required participant contribution for AGMA Health Fund Standard Plan coverage has been paid by your employer pursuant to a payroll deduction (or otherwise), your Individual Account may not be used to reimburse or otherwise cover the cost of that contribution.
    - For another example, if your employer has paid for the cost of coverage under the AGMA Health Fund Standard Plan for your spouse and/or dependents, your Individual Account may not be used to reimburse or otherwise cover that cost.
    - For another example, if the cost of coverage under the AGMA Health Fund Healthy Savings Plan for your spouse and/or dependents has been paid by your employer pursuant to a salary reduction (or otherwise), your Individual Account may not be used to reimburse or otherwise cover that cost.
- The cost of premiums paid on a pre-tax basis, whether through payroll or salary reduction or otherwise.

1. Obtaining Traditional Health Coverage and Dental Insurance for the Participant Through the AGMA Health Fund Standard Plan

If you (the Participant) meet the eligibility requirements stated below, you can use your Plan Balance to obtain the traditional health coverage and/or dental insurance provided by the AGMA Health Fund Standard Plan. (You may not however obtain coverage under the AGMA Health Fund Healthy Savings Plan pursuant to this Section.)

Health Coverage

The AGMA Health Fund Standard Plan provides comprehensive hospital, medical, and prescription drug benefits and optional dental benefits.

In order for a Plan Balance to be used to obtain this coverage starting on any September 1, a Participant must have sufficient employment under the applicable collective bargaining agreement for employer contributions to their Reimbursement Plan Individual Account during the two years ending on the preceding June 30. Similarly, in order for a Plan Balance to be used to obtain this coverage starting on any March 1, a Participant must have sufficient employment for employer contributions to their Reimbursement Plan Individual Account during the two years ending on the preceding December 31.

For example, in order to be eligible to use a Plan Balance to obtain Standard Plan health coverage, starting September 1, 2024, a Participant must meet **ONE** of the following requirements:

(1) Have a minimum of $1,200 in employer contributions to the Participant's Reimbursement Plan Account based on Covered Employment in the period from July 1, 2022 through June 30, 2024,

OR

(2) Have at least 32 weeks of Reimbursement Plan Covered Employment in the period from July 1, 2022 through June 30, 2024.

The same levels of employment during the two years ending on December 31 of a given year would make a Participant eligible to use their Plan Balance to obtain Standard Plan health coverage starting on March 1 of the next year.

Dental Insurance

If you meet the eligibility requirements stated below you can also enroll in voluntary dental insurance through the Standard Plan. You can elect dental coverage if you are also electing medical coverage. In addition, even if you do not qualify for traditional health coverage through the Standard Plan, you can enroll in dental coverage available under the Standard Plan starting on a March 1 or a September 1 if you have sufficient Covered Employment in the applicable prior two-year period. For example, you can enroll in such dental coverage starting on September 1, 2024, if you meet **ONE** of the following requirements.

(1) Have a minimum of $300 in employer contributions to your Reimbursement Plan Individual Account based on Covered Employment in the period from July 1, 2022 through June 30, 2024,

OR

(2) Have at least 8 weeks of Reimbursement Plan Covered Employment in the period from July 1, 2022 through June 30, 2024.

The same levels of employment during the two years ending on December 31 of a given year would make a Participant eligible for such dental coverage starting on March 1 of the next year.

If you are eligible to enroll in the AGMA Health Fund Standard Plan (either medical or dental coverage) under the rules above, you will be able to use your Plan Balances to defray the cost of payments required for such coverage, unless such payments have already been made on a pre-tax basis (through payroll deduction or otherwise). Any eligible costs above your Old Plan Balance will then be deducted from your New ACA Plan Balance, and any remaining costs will be billed to you directly.

If you enroll in the Standard Plan, you will be subject to the rules of that Plan, including the special enrollment periods to add dependents, and COBRA continuation coverage if you lose coverage due to a qualifying event. Please consult the Summary Plan Description for the Standard Plan, available from the Fund Office, for further information.

If you would like additional information on this program and the coverage provided by the AGMA Health Fund Standard Plan, please contact the Fund Office at 212-765-3664 or via email at info@agmafunds.org.

2. <u>Obtaining Coverage for Eligible Dependents Under the AGMA Health Fund Standard or Healthy Savings Plans</u>

If any of your Eligible Dependents are eligible to enroll in the AGMA Health Fund Standard or Healthy Savings Plans (either medical or dental coverage), you can use your Plan Balances to defray the cost of payments required to enroll such Dependents in those Plans, unless such payments have already been made on a pre-tax basis (through payroll deduction or otherwise).

Eligible Dependents who are enrolled in the AGMA Health Fund Standard or Healthy Savings Plans will be subject to the rules of those Plans, including the special enrollment periods to add dependents, and COBRA continuation coverage if they lose coverage due to a qualifying event. Please consult the Summary Plan Description and other information describing those Plans, available from the Fund Office, for further information.

If you would like additional information on this program and the coverage provided by the AGMA Health Fund Standard and Healthy Savings Plans, please contact the Fund Office at 212-765-3664 or via email at info@agmafunds.org.

3. Medical Reimbursement Program - Medical Expenses and the Cost of an "Outside" Health Policy or Plan

The AGMA Health Fund Reimbursement Plan Medical Reimbursement Program lets you use your Plan Balance to obtain reimbursement for qualified medical expenses that have not otherwise been paid, except that you may not obtain reimbursement for member cost-sharing (such as copays, coinsurance, or deductibles) incurred under individual health policies.

The Medical Reimbursement Program also reimburses premiums and costs incurred on a post-tax basis to obtain coverage under other qualified medical plans (other than the AGMA Health Fund Standard or Healthy Savings Plans) that cover you and your dependents, except for premiums and costs for individual health policies (including plans purchased through an ACA Marketplace or an individual insurance company). This kind of reimbursement is available with respect to health insurance or other coverage through your spouse's employer that requires an additional premium to include you as a dependent. **Premiums for health coverage that do not include the Participant in the coverage do not qualify for reimbursement from Old Plan Balances**. Premiums for dependents' coverage that does not include the Participant can only be reimbursed from New ACA Plan Balances, as described in Section 5.B below.

Expenses incurred by the Participant for Medicare premiums and cost-sharing under Medicare can also be reimbursed under the Medical Reimbursement Program, subject to special rules set forth below.

Please note that any individual seeking reimbursement for health coverage premiums, or other payments that are required to obtain health coverage, must certify that such premiums or payments were paid on a post-tax basis. Premiums or payments that were paid on a pre-tax basis, such as by pre-tax deduction from wages, are not eligible for reimbursement.

A. What Premiums for Outside Medical Coverage Qualify for Reimbursement?

First, a medical coverage policy may not be an individual health insurance policy (such as a plan purchased through an ACA Marketplace or an individual insurance company).

Additionally, the plan or policy must provide you (and if applicable your dependents) with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc. Premiums for medical coverage that do not include the Artist in the coverage do not qualify for reimbursement from Old Plan Balances. Premiums for dependents' coverage that does not include the Participant can only be reimbursed from New ACA Plan Balances, as described in Section 5.B below.

Premiums for Medicare coverage may be reimbursed subject to the rules set forth in Section 5.A.2.d below.

Premiums for **Long Term Care insurance** that meet the Internal Revenue Code requirements for qualified Long Term Care insurance contracts **are covered.**

Premiums for Life Insurance and accidental death and dismemberment insurance, loss of income insurance, or automobile insurance **are not covered.**

In addition, the premium must meet **all** of the following requirements (please also see Section 8 regarding forfeitures of contributions):

- It covers a policy or plan that is in effect at the time the reimbursement is to be paid,
- The claim for reimbursement must be filed no later than six months after the end of the calendar year in which the premiums were payable,
- It must be documented with proof of payment and a description of the medical coverage provided (*i.e.*, a premium billing statement and canceled check or other proof of payment, and a statement that the premiums

were paid on a post-tax basis.) (Please also see the Claims Procedure outlined in Section 7.B).

b. What Medical Expenses Qualify for Reimbursement?

In order to qualify for reimbursement, a medical expense must meet **all** of the following requirements (please also see Section 8 regarding forfeitures):

- It must appear in the list of **"Expenses That Can Qualify for Reimbursement,"**
- It does not constitute member cost-sharing (such as copays, coinsurance, or deductibles) incurred under individual health insurance policies,
- It has not been, or will not be, reimbursed from another source,
- The claim for reimbursement must be filed no later than six months after the end of the fiscal year in which the medical expense was incurred. The Fund's fiscal year runs from July 1 through August 31 of the following year. Thus claims for any fiscal year must be filed by the end of February following the fiscal year in which the claims were incurred. (If you can document to the satisfaction of the Trustees that the claim was filed beyond this deadline because of extenuating circumstances related to the health of the Participant or an immediate family member, the claim will be paid to the extent of the Individual Account balance at the time of filing.)
- It must be documented by a detailed statement from the claimant including the name, address, telephone number and tax identification number of the provider, plus a written statement from the claimant that the medical expense has not been reimbursed and is not reimbursable under any other health policy or plan and a written statement from the provider that the medical expense has been incurred and the amount thereof (please also see the Claims Procedure outlined in Section 7.B), and
- It must be rendered by a licensed provider as mandated by law.

c. Expenses That Can Qualify for Reimbursement

Expenses that can qualify for reimbursement include the following:

- Abortion (Only legal abortions),
- Acupuncture (Reimbursement limited to 14 visits per calendar year),
- Treatment for Alcoholism/Substance Abuse,
- Ambulance (To and from hospital only),
- Ambulette (To and from a medical facility only),
- Annual Physical Exam (Reimbursement limited to one exam per calendar year),
- Artificial Limb,
- Artificial Teeth,
- Bandages,
- Birth Control Pills (Must be prescribed by a doctor),
- Breast Pumps and Supplies,
- Chiropractors (Reimbursement limited to 40 visits per calendar year),
- Christian Science Practitioner medical care,
- COVID Tests,
- Cosmetic Surgery (Only if it is necessary to improve a deformity arising from, or directly attributable to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease, as evidenced by a statement in writing by the examining or treating physician),
- Crutches (Reimbursement for rental fee will not exceed the purchase price),
- Deductibles and Coinsurance Payments,
- Dental Treatment,
- Diaper/Diaper Service (Must be three years of age or older and required to relieve the effects of a particular disease),
- Diagnostic devices (e.g., diabetes blood sugar test kits),

- Electronic Body Scans,
- Fertility enhancement (e.g., in vitro fertilization),
- Guide dogs or service animals to assist a visually-impaired or hearing- impaired person, or a person with other physical disabilities,
- Hearing Aids (Maximum reimbursement of two exams and one hearing aid device per ear per calendar year),
- Hospital Services (Expenses for telephone, television and extra meals are not covered),
- Inhalation therapy devices and other prescribed mechanical, electronic and other devices for the treatment of medical conditions,
- Insulin Syringes,
- Laboratory Fees,
- Lodging that is primarily for and essential to medical care (cannot exceed $50 for each night, for each individual),
- Medical Care and Services of any type falling within definition of "medical care" under Internal Revenue Code Section 213(d) (see IRS Publication 502), subject to the limitations otherwise set forth herein,
- Medicine (Prescription drugs, medications, insulin and over the counter medication if prescribed by a doctor for a specific medical condition),
- Nursing Services (Nursing expenses must be for services connected with caring for the patient's conditions, such as giving medication or changing dressings. Services must be rendered by an RN, LPN or a health aide who reports to a licensed or certified home health care agency. Benefits are not available for services rendered by immediate family members or someone who ordinarily lives in your home),
- Operations (Expenses must be for legal operations),
- Oxygen,
- Pregnancy Test Kits,
- Psychiatric Care, Psychoanalysis and Psychologist visits (Reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year),
- Sterilization,
- Therapy,
- Transplants,
- Transportation primarily for, and essential to, medical care,
- Vision Care including exams, eyeglasses, contact lenses (No benefits are payable for lenses which are not prescribed by an ophthalmologist or an optometrist), cost of equipment and materials required for using contact lenses (such as saline solution and enzyme cleaner) and laser surgery,
- Well Baby Care (Reimbursement limited to 40 inpatient and 50 outpatient visits per calendar year),
- Wheelchair (Reimbursement for rental fee will not exceed purchase price),
- Wigs (Purchased by patients, on advice of a physician, who lose hair due to disease), and
- X-ray Fees (Including one routine mammogram per year)

d. Medicare Expenses

"Medicare Expenses" are defined as expenses for (a) Medicare premiums, and (b) cost-sharing on claims submitted to Medicare for Medicare-covered items or services.
General Rule. Except as provided in the End Stage Renal Disease ("ESRD") Rule below, Plan Balances may be used to reimburse a participant's Medicare Expenses for periods when the Participant is either:

1. enrolled in group health plan coverage other than the Plan based on the current employment of the Participant, the Participant's spouse, or, if the Participant is under age 65 and eligible for Medicare based on a disability, any family member (including a domestic partner); or
2. not eligible for any such group health plan coverage.

Eligibility for coverage under a retiree health plan does not constitute eligibility for group health plan coverage based on current employment as described in (1) above.
As a result, if you are eligible for retiree health coverage, but are not eligible for any group health plan coverage based on current employment as described in (1) above, your Medicare Expenses can be reimbursed by the Plan (regardless of whether you enroll in the retiree coverage or not).

General Rule Summary: If you are eligible for group health plan coverage based on current employment as described in (1) above, you must be enrolled in such coverage to have your Medicare Expenses reimbursed by the Plan.

If you are not eligible for any such employment-based group health plan coverage, you can have your Medicare Expenses reimbursed by the Plan. This rule applies even if you are eligible for retiree health coverage, regardless of whether you enroll in the retiree health coverage.

End Stage Renal Disease ("ESRD") Rule. For Participants who are eligible for Medicare based on end stage renal disease ("ESRD"), a different rule applies. Such Participants may use Plan Balances to reimburse their Medicare Expenses during any period of their ESRD-based Medicare eligibility, except that during the first 30 months of such eligibility, the Participant must be either enrolled in or ineligible for group health plan coverage other than the Plan in order to receive such reimbursement. Under this ESRD Rule, whether the other group health plan coverage is based on the current employment of the Participant or another person (as referenced in the General Rule above) is irrelevant.

PLEASE NOTE: Medicare Expenses of dependents are not reimbursable. Only a participant's Medicare Expenses may be reimbursed by the Plan. Reimbursement for Medicare Expenses is also subject to the other rules set forth herein.

Examples. The following examples illustrate how the Medicare Expenses may be reimbursed under the Plan.

Example 1. Participant A is age 65 or over, eligible for Medicare based on age, unmarried, and unemployed. Participant A can obtain reimbursement for Medicare Expenses from the Plan while those conditions apply, subject to the other Plan rules.

Example 2. Participant A is age 65 or over, eligible for Medicare based on age, unmarried, unemployed, and eligible for retiree health coverage. Participant A can obtain reimbursement for Medicare Expenses from the Plan while those conditions apply, regardless of whether Participant A enrolls in the retiree health coverage, subject to the other Plan rules.

Example 3. Participant A is age 65 or over, eligible for Medicare based on age, and unmarried. Participant A is currently employed, but is not eligible for any group health plan coverage based on that employment. Participant A can obtain reimbursement for Medicare Expenses from the Plan while those conditions apply, subject to the other Plan rules.

Example 4. Participant A is age 65 or over and eligible for Medicare based on age. Both Participant A and their spouse are retired. Participant A is not eligible for any group health plan coverage based on their own current employment or that of their spouse. Participant A can obtain reimbursement for Medicare Expenses from the Plan while those conditions apply, subject to the other Plan rules.

Example 5. Same facts as Example 4, except that Participant A's spouse is actively working and Participant A is eligible for group health plan coverage based on their spouse's current employment. If Participant A enrolls in such group health plan coverage, they can obtain reimbursement from the Plan for any Medicare Expenses they incur while so enrolled, subject to the other Plan rules. If Participant A does not enroll in the group health plan coverage available through their spouse, they cannot obtain reimbursement for Medicare Expenses through the Plan.

Example 6. Participant B recently became eligible for Medicare based on ESRD and is not eligible for any group health plan coverage (other than the Plan). Participant B can obtain reimbursement from the Plan for Medicare Expenses while those conditions apply, subject to the other Plan rules.

Example 7. Participant B recently became eligible for Medicare based on ESRD and is also eligible for group health plan coverage (other than the Plan) during the first 30 months of their ESRD-based Medicare eligibility. To obtain reimbursement from the Plan for Medicare Expenses incurred during that 30-month period, Participant B must be enrolled in such group health plan coverage during that period. After the end of that period, Participant B can obtain reimbursement from the Plan for Medicare Expenses without being enrolled in such group health plan coverage, even if they are eligible for it.

PLEASE NOTE: These examples are for illustration purposes only, and do not alter Plan rules as described herein.

Medicare Expenses—Common Cases[1]

If you are eligible for Medicare based on age (65):

Your Medicare Expenses can be reimbursed if:

1) You are unemployed and are not eligible for any group health plan coverage other than the Plan ("other group health plan coverage");

2) You or your spouse are employed and you are enrolled in other group health plan coverage based on the current employment of you or your spouse; or

3) You are eligible for retiree health coverage and are not eligible for any other group health plan coverage based on the current employment of you or your spouse. (In this case, your Medicare Expenses can be reimbursed regardless of whether you are enrolled in the retiree coverage or not.)

Your Medicare Expenses cannot be reimbursed if:

1) You are unemployed and are eligible for other group health plan coverage based on the current employment of your spouse, but not enrolled in such coverage; or

2) You or your spouse are employed and you are eligible for other group health plan coverage based on the current employment of you or your spouse, but not enrolled in such coverage.

[1]*If you are eligible for Medicare based on disability or End-Stage Renal Disease ("ESRD"), somewhat different rules apply, as set forth above.*

B. New ACA Plan Balances

1. Reimbursement from New ACA Plan Balances

Covered expenses will be reimbursed from your New ACA Plan Balance after your Old Plan Balance is exhausted or as described in this Section 5.B.1.

a. Types of Expenses

In addition to the expenses listed in Section 5.A above, the following types of expenses can be reimbursed from your New ACA Plan Balance (but not from your Old Plan Balance):

- Premiums for group health coverage for covered dependents, even if the Participant is not included in the coverage,
- Menstrual Care Products,
- Over-the-counter drugs without a prescription, and
- Amounts paid on or after January 1, 2020 for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of the Coronavirus Disease 2019.

b. Use by Surviving Dependents

After your death, your New ACA Plan Balance will be available for reimbursement of covered expenses incurred prior to your death and for reimbursement of covered expenses incurred by your surviving spouse and dependents if they are enrolled in the Reimbursement Plan at the time of your death, or if they are eligible and enroll within 3 years after your death. Claims by your surviving spouse and/or surviving dependents are subject to the claim filing deadlines and other applicable rules set forth herein.

2. Plan Balance Crediting Requirements: Standard or Healthy Savings Plan Eligibility and Enrollment in Group Health Plan Coverage

New Contributions (contributions received on or after September 1, 2014) can only be credited to your New ACA Plan Balance; they cannot be credited to your Old Plan Balance. Contributions can only be credited to your New ACA Plan Balance during periods when:

(i) you are eligible for Standard or Healthy Savings Plan coverage, and
(ii) you and any dependents for whom you seek reimbursement from your New ACA Plan Balance have coverage through enrollment in either:

(a) The Standard or Healthy Savings Plan or
(b) Eligible alternate coverage, as defined below.

"Eligible alternate coverage" is group health plan coverage that is of minimum value, as defined under applicable law. (Whether coverage is of minimum value should be set forth on the applicable summary of benefits and coverage.) Medicare is not considered a group health plan, and thus does not constitute eligible alternate coverage. Individual plan coverage obtained from the Marketplace or directly from an insurance carrier is not eligible alternate coverage.

You and your dependents need not have the same coverage, so long as each person for whom reimbursement is sought is covered by Standard Plan, Healthy Savings Plan, or eligible alternate coverage. You must provide the Plan with any required documentation of any such eligible alternate coverage during the required periods in order to receive reimbursement from your New ACA Plan Balance for expenses you or your dependents incur.

Any contribution amounts received during periods when the Participant and any enrolled dependents lacked Standard Plan, Healthy Savings Plan, or eligible alternate coverage ("Excess Credit Amounts") will (a) not be credited to a participant's Plan Balance, or (b) if already credited, will be deducted from the Participant's Plan Balance.

Such Excess Credit Amounts will then be redirected to provide the Participant and (if the redirected amounts are sufficient) dependents with coverage under the Standard Plan or Healthy Savings Plan, provided that the Participant must elect and enroll in such coverage within 31 days of receiving notice of its availability. The elected coverage will be provided starting with the month after the Plan receives notice of the Participant's election.

If the Participant does not timely elect Standard or Healthy Savings Plan coverage, the redirected Excess Credit Amounts will be allocated to the general assets of the AGMA Health Fund. Similarly, if the Participant initially elects such coverage and disenrolls before the redirected Excess Credit Amounts are exhausted, the remaining amounts will be allocated to the AGMA Health Fund's general assets. Any redirected Excess Credit Amount that is insufficient to pay for a full month of Standard or Healthy Savings Plan coverage will also be allocated to the general assets of the AGMA Health Fund.

If any Excess Credit Amounts are used for reimbursement, the Trustees, or any duly authorized agent(s) of the Trustees, have full authority, in their sole and absolute and discretion, to recover those amounts and deduct any amounts not returned from any future Reimbursement Plan contributions. (Please also see Section 7.E regarding recovery of overpayments.) Absent return or offset during the same calendar year, the amounts will be taxable.

Contributions received during periods when a Participant is enrolled in other qualifying group health plan coverage but their enrolled dependents (if any) are not enrolled in other qualifying group health plan coverage can still be credited to a Participant's Plan Balance, but such credits may only be used to reimburse the Participant's (not the enrolled dependents') claims. For example, if Participant A is enrolled in other qualifying group health plan coverage in June 2024, but Participant A's dependents are not enrolled in such coverage during that month, contributions received in June 2024 for Participant A could only be used to reimburse claims for Participant A. They could not be used to reimburse claims for Participant A's dependents.

3. Opt Out, Waiver, and Reinstatement of New ACA Plan Balances

You may permanently opt out of and waive future reimbursements from your New ACA Plan Balance:

(i) Effective January 1 of any year, if you submit notice of the opt out/waiver to the Fund Office in advance of that

date, and/or

(ii) Upon termination of your Reimbursement Plan covered employment, if you submit notice of the opt out/waiver to the Fund Office within 60 days after such termination.

Any such opt out and waiver will also apply to your eligible dependents.

You may wish to exercise this opt-out/waiver option in order to be eligible for subsidies to purchase coverage through an ACA Marketplace. (Access to your New ACA Plan Balance would make you ineligible for such subsidies.)

If you do exercise this opt-out/waiver option, your waived New ACA Plan Balance will be reinstated on the earlier of:

(i) the January 1 following the date of the opt out/waiver, unless you renew your opt-out/waiver before then; or
(ii) the date of your death.

Any such reinstated New ACA Plan Balance may not be used to reimburse expenses incurred during the period after waiver and prior to the reinstatement. If you begin working in Covered Employment following a waiver, contributions made to the Reimbursement Plan will not be available for reimbursement until your prior New ACA Plan Balance is reinstated. For example, if Participant A waives Plan coverage effective January 1, 2024 and begins working in Covered Employment on September 1, 2024, contributions made for Participant A after September 1, 2024 will not be available for reimbursement until reinstatement of Participant A's New ACA Plan Balance on January 1, 2025 (provided Participant A has not renewed the opt-out/waiver before then).

Please note that during any opt-out/waiver period, your Balances will continue to be subject to reduction for administrative fees, investment losses, and forfeiture as otherwise described herein.

If the Plan becomes aware that a Participant with a waived New ACA Plan Balance has died, the Plan will use information it has on file to attempt to notify any surviving dependents that the Balance has been reinstated. Such dependents must enroll in the Reimbursement Plan within 3 years of the Participant's death in order to receive reimbursement from a New ACA Plan Balance that has been reinstated as a result of the Participant's death, and may opt out of and waive future reimbursements from the Participant's New ACA Plan Balance annually, pursuant to the rules set forth above. Participants may wish to advise their dependents to notify the Plan of the Participants' death in order to take advantage of this aspect of the Plan.

6. DIRECTION OF CONTRIBUTIONS TO OTHER PLANS

If an employee is covered by a collective bargaining agreement that provides for employer contributions to be made for the employee to AGMA Health Fund Reimbursement Plan or the Healthy San Francisco Plan (each an "Account Plan") instead of to the AGMA Health Fund Standard or Healthy Savings Plans, the employee may elect to have contributions made to such Account Plan (i.e., may make an "Account Plan Election") if:

(i) the employee became newly eligible to have contributions made to the AGMA Health Fund in 2021,
(ii) the employee establishes that the employee had other qualifying group health coverage and agrees to notify the Plan if such coverage ceases, in such manner as the Plan shall require, and
(iii) the employee made the Account Plan Election during the employee's initial Standard Plan enrollment period beginning on or after July 1, 2021.

Starting in 2022, the option to make an Account Plan Election was limited to those whose last election since January 1, 2018 was an Account Plan Election. For example, an individual who elected to have contributions made to the AGMA Health Fund Reimbursement Plan in 2019, who had a break in contributions in 2020, and who then became eligible for AGMA Health Plan contributions again in 2022 could have made an Account Plan Election pursuant to such 2022 eligibility. By contrast, if an individual had the opportunity to elect to have contributions made to the AGMA Health Fund Reimbursement Plan in 2019 but did not make that election, and then had a break in contributions in 2020 and became eligible for AGMA Health Plan contributions again in 2022, the individual would not have been eligible to make an Account Plan Election pursuant to such 2022 eligibility.

Contributions may only be made to an Account Plan while the employee is covered by group health plan coverage providing minimum value. Contributions must be made to the AGMA Health Fund Standard or Healthy Savings Plan during any period in which such other coverage is not in effect.

7. CLAIMS & APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the AGMA Health Fund Reimbursement Plan (the Plan). It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. These rules apply to both Participants and surviving dependents (after a Participant's death), except where otherwise indicated.

How to File a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A claim form may be obtained from the Third-Party Administrator, Administrative Services Only, Inc., by calling 1-866-263-1185, or through its website, www.asonet.com, or from the Fund Office by calling 212-765-3664, or through its website at https://www.agmaretirement-health.org/forms/.

A. Filing Claims - Reimbursement of Premiums or Other Payments Required for Coverage:

After your premium or other payment that is required to obtain health coverage has been paid (other than for coverage provided through the AGMA Health Fund Standard or Healthy Savings Plans, or an individual health insurance policy), you may apply for reimbursement with the Third-Party Administrator (see Section 3 for address). If you choose to obtain coverage through the AGMA Health Fund Standard Plan for yourself (if you are eligible to do so under Section 5.A.1 above), or for your family through either the AGMA Health Fund Standard or Healthy Savings Plans, you can elect for the Third-Party Administrator to automatically deduct the premium or other payment required for such coverage from your Individual Account. In that case, there is no need to file a claim for reimbursement. Please note, however, that if any such premiums or payments were paid pursuant to a salary reduction or otherwise, your Plan Balance may not be used to cover such premiums or payments.

To file a claim: Attach copies of the premium or payment statement and proof of payment (i.e. a copy of canceled check); and/or copies of pay stubs that show the payment for your coverage and a statement that premiums or payments were paid on a post-tax basis. If you are seeking reimbursement for Medicare premiums or cost-sharing, you must submit an attestation stating that, in the Medicare coverage period for which such premiums were paid or in which such expenses were incurred, you were (1) enrolled in other group health plan coverage based on your own employment or that of another person (such as a spouse) or (2) you were not eligible for any such other group health plan coverage.

B. Filing Claims - With Carriers or Plans:

Once you have incurred a medical expense that is covered by a health insurance policy or health plan (including but not limited to insurance through the AGMA Health Fund Standard Plan), you must file your claim for benefits directly with that insurance company or plan. The Reimbursement Plan will not make claims determinations on expenses that are covered by an insurance policy or another health plan.

For example, if you incur a medical expense that is covered by an insurance policy of which you are a beneficiary, you must file your claim for payment of that expense directly with the insurance company, not with the Reimbursement Plan or the Third-Party Administrator. The Reimbursement Plan will only accept claims for the reimbursement of premiums, other payments that are required to obtain health coverage, and uninsured or non-reimbursed medical expenses; not claims paid or payable under an insurance policy or another source of health benefits coverage.

C. Filing Claims - Reimbursement of Uninsured Medical Expenses:

After you incur a qualifying medical expense and receive an Explanation of Benefits document from all medical insurance or other health plans that you are covered under, you may apply for reimbursement of the unpaid balance of your expenses. Do *not file* a claim if your expense is paid in full by another source or if the incurred expense does not meet

the requirements for qualified expenses.

To file a claim: Obtain a claim form from the Third-Party Administrator or the Fund Office. Complete it in its entirety and sign the applicable statements. Attach copies of the itemized bills (e.g., a universal/CMS 1500 or UB-04 form) for the qualified expenses and any corresponding Explanation of Benefit vouchers to the claim form. All claims must meet the requirements to qualify for reimbursement as a medical expense as described above to be considered eligible for reimbursement. *You must file separate completed, signed and dated forms for each family member*. Claims made by surviving dependents after a participant's death will be processed and paid on a first come, first served basis, based on the time when a claim is received by the Third-Party Administrator.

Reimbursements are payable only to you, the Participant or, after your death, to your covered surviving dependents, not to an insurance company or medical provider.

The following information must be completed in order for your request for benefits to be a claim, and for the Third-Party Administrator to be able to decide your claim, to the extent such information is available.

- Participant name
- Patient name
- Patient Date of Birth
- Date of Service
- CPT (the code for physician services and other health care services found in the current edition of the *Current Procedural Terminology*, as maintained and distributed by the American Medical Association)
- ICD (the diagnosis code found in the current edition of the *International Classification of Diseases,* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details
- An attestation that, if reimbursement is sought from a New ACA Plan Balance, reimbursement is being claimed only for the Participant or enrolled dependents who were enrolled in Standard Plan, Healthy Savings Plan, or eligible alternate coverage during the period when the Participant was in Covered Employment.

When Claims Must Be Filed

Claims should be filed as soon as possible after being incurred. Claims incurred in the period from September 1, 2021 through August 31, 2023 must be filed (i.e., received by the Third Party Administrator) on or before June 30, 2024. For claims incurred on or after September 1, 2023,

- Claims for reimbursement of outside health plan premiums pursuant to Section 5.A.2.a above must be filed within six months after the close of the calendar year in which they were incurred, i.e., by June 30 of the following year.
- All other claims must be filed by six months after the close of the Plan fiscal year in which they are incurred, i.e., by the end of the following February. **The Plan's fiscal year is September 1 – August 31.**

The following examples illustrate these rules:

Example 1. If you incurred a covered outside plan premium expense in November 2023, the claim would have to be filed by June 30, 2024.

Example 2. You have health coverage under your spouse's plan. You have a medical service on October 24, 2023 of a kind that is eligible for reimbursement by this Plan, and you pay the expenses incurred for that service out of pocket. A claim for reimbursement of those expenses would have to be filed with this Plan by February 28, 2025 (six months after the close of the Plan fiscal year ending August 31, 2024, in which the expenses were incurred).

Example 3. You have health coverage with your new employer. You incur medical expenses on January 1, 2024 that

your new employer's plan will not pay for, and that are for a service of a kind that is eligible for reimbursement under this Plan. A claim for reimbursement of those expenses would have to be filed by February 28, 2025.

Example 4. You incur expenses for a qualifying medical service on May 2, 2024. A claim for reimbursement would have to be filed by February 28, 2025.

Example 5. You incur expenses for a qualifying medical service on September 15, 2024. A claim for reimbursement would have to be filed by February 28, 2026 (six months after the close of the Plan fiscal year ending August 31, 2024, in which the expenses were incurred).

If a claim is filed beyond the deadline, the Trustees may consider any evidence of extenuating circumstances related to the health of the Participant or an immediate family member. If the Trustees then determine that an extension is warranted, the claim will be processed and considered for payment to the extent of the Individual Account balance at the time it is filed.

Notwithstanding the foregoing, the forfeiture rules described in Section 8 below will be applied annually as of February 28/29 as described in that Section.

Where to File Claims

Your claim will be considered to have been filed as soon as the Third-Party Administrator receives it. Claims should be filed with the Third-Party Administrator at the following address:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563-9010

Claims may also be submitted electronically using the Third-Party Administrator's web portal at https://www.asonet.com/Member.aspx.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A HIPAA Authorization Form can be obtained from either the Third-Party Administrator or the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

When you file a claim as described above, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing condition and you have filed a claim within the past Plan year period. Mail any further bills or statements for any Medical or Hospital services eligible for reimbursement by the Plan to the Third-Party Administrator as soon as you receive them.

Ordinarily, you will be notified of the decision on your claim within 30 days from the Third-Party Administrator's receipt of the claim. The Third-Party Administrator may extend this period one time up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Third-Party Administrator expects to render a decision.

If an extension is needed because the Third-Party Administrator needs additional information from you, the extension notice will specify the information needed. In that case you will have 60 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 60 days or until the date you respond to the request (whichever is earlier). The Third-Party Administrator will then have 15 days to make a decision

on a claim and notify you of the determination.

D. Your Rights to Review and Appeal

This section applies to all claims filed pursuant to this Plan. A claim for an expense covered under an insurance policy is not reviewed by the Third-Party Administrator, and thus this section does not apply (See Section 7.B).

If your claim for reimbursement is denied because there are insufficient funds in the Individual Account at the time the claim is processed, you may resubmit the claim once there are adequate funds in your Individual Account, provided that your renewed claim meets all time restrictions set out in Sections 5, 7, and 8.

Benefits under the Plan may be denied, in whole or in part, in instances where a claim is filed improperly, a claim is not covered under the Plan, or the individual is not eligible to receive the benefit claimed.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) from the Third-Party Administrator. This notice will state:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- The specific reason(s) for the determination, including any denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- A statement of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist individuals with internal claims and appeals and external review processes.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim for benefits is denied, in whole or in part, the Third-Party Administrator will provide you with a written explanation of the reasons for the denial within 30 days from the date your claim is received, plus any applicable extension period as described above. In addition to a description of the reason for the denial, you will be advised of the specific provisions of the Plan on which the denial is based. You will be instructed as to exactly what, if any, additional information or material is needed to process your claim and why it is needed. Finally, you will be advised of the steps which should be taken to appeal the denial of benefits to the Board of Trustees of the AGMA Health Fund Reimbursement Plan.

How and When to File a Request for Review of a Denied Claim

You must submit a request for review of a denied clam in writing within 180 days following your receipt of notice of the claim denial. Such request should be addressed to the Trustees and sent to the Fund Office at 305 7th Ave., Suite 2B, New York, NY 10001 by mail or to info@agmafunds.org by email.

Review Process

The review process works as follows:

You have the right to submit written comments, documents, records, testimony, and other information relating to the claim.

You have the right to copies of documents relevant to your claim, upon request and free of charge. A document, record, or other information is relevant if it was relied upon by the Third-Party Administrator in making the decision; if it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); if it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or if it constitutes a statement of plan policy regarding the denied treatment or service.

Your claim will be reviewed by the Board of Trustees or a duly designated committee thereof, which is not subordinate to (and shall not afford any deference to) the person who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If any new or additional evidence is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, such evidence and/or rationale will be provided to you, free of charge, as soon as possible and sufficiently in advance of the date on which the final decision on review is required to be provided to give you a reasonable opportunity to respond prior to that date. If such evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the period for providing notice of the decision on review will be tolled until such time as you have an opportunity to respond. After you respond or fail to respond with a reasonable time, the Plan will notify you of the decision on review as soon as it can reasonable do so, taking into account the medical exigencies.

In addition, before a claim on review is denied based on a new or additional rationale, you will receive a statement of the rationale, free of charge.

Timing of Decision and Notice of Decision on Review

Ordinarily, decisions on requests for review of denied claims will be made at the next regularly scheduled meeting of the Board of Trustees (or duly designated committee thereof) following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision in writing as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning)
- The specific reason(s) for the determination, including any denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. This description will include a discussion of the decision.
- Reference to the specific plan provision(s) on which determination was based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that is available upon request at no charge.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

- A statement of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist individuals with internal claims and appeals.
- A statement of your right to bring an action under ERISA Section 502(a) following an adverse benefit determination on review.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502 (a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided, or in which the premiums were paid.

E. Recovery of Overpayments

If for any reason benefit payments are made to any person from the Fund in excess of the amount which is due and payable for any reason (including, without limitation, mistake of fact or law, reliance on any false or fraudulent statements, information, or proof submitted by a Participant or dependent, or a Participant's or dependent's failure to timely inform the AGMA Health Fund of relevant information, such as a divorce), the Trustees (or the Plan Administrator or any other designee duly authorized by the Trustees) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest and costs). That authority shall include, but not be limited to:

- the right to reduce benefits payable in the future to the person who received the overpayment;
- the right to reduce benefits payable to a dependent who is, or may become, entitled to receive payments under the Plan following the death of that person, and/or;
- the right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and costs) against the person who received the overpayment, or such person's estate.

8. FORFEITURES

The AGMA Health Fund Reimbursement Plan has a Forfeiture Provision that is applied annually as of February 28/29 (i.e., the last date in February) against infrequently used Individual Accounts. The Plan requires employer contributions to be used within three fiscal years of receipt. Any contributions in an Individual Account that are not used for services covered by this Plan for a period of three consecutive fiscal years will be forfeited. However, the maximum amount that can be forfeited from an Individual Account in any one year is $500.

For example, contributions received and deposited in a Participant's Individual Account by August 31, 2019, if not used to reimburse expenses incurred by August 31, 2022, and if not submitted to the Third-Party Administrator by February 28, 2023, would be forfeited up to $500 and used to offset the Administrative Expenses of the Health Fund. Thus, if you incurred no expenses in the Fiscal Years ending August 31, 2020, 2021, or 2022 and had $800 contributed to your Individual Account between September 1, 2018 and August 31, 2019, $500 would have been forfeited on March 1, 2023 and used to offset Administrative Expenses for all Fund participants.

Any amount subject to forfeiture above the $500 limit is carried over for another fiscal year. In the above example, the $300 remaining would be available for expenses incurred by August 31, 2023 and submitted by February 29, 2024 or subject to forfeiture on March 1, 2024.

Any Participant who can demonstrate with evidence satisfactory to the Trustees that they were unaware of the forfeiture because the Third-Party Administrator had an incorrect address on file may apply within 24 months of the forfeiture for reinstatement of any amounts forfeited.

Upon the death of a Participant with an Individual Account, any remaining balance may be used for eligible expenses of the Participant prior to the Participant's death, provided that claims for such expenses are submitted timely. A deceased

Participant's New ACA Plan Balance may also be used for eligible expenses incurred by the Participant's surviving dependents, provided they are submitted timely. Reimbursements after the Participant's death are also subject to the otherwise applicable rules set forth herein. Subject to the other forfeiture rules set forth above, the New ACA Plan Balance of a deceased Participant shall be forfeited upon:

1. The expiration of a 3-year period after the Participant's death, unless an enrolled dependent has submitted a timely claim for expenses within that period; or
2. The expiration of a 3-year period in which no expenses for an enrolled dependent have been timely submitted.

A portion of the forfeited contributions are applied against this Plan's administrative expenses, thus reducing such charges to Participants who actively draw benefits from the Fund. Another portion is applied to the AGMA Health Fund Standard and Healthy Savings Plans' administrative expenses, thus reducing their cost to everyone they cover, including the Reimbursement Plan Participants who buy the Standard Plan. The AGMA Health Fund will apply 95% of the amounts forfeited to the expenses of the Standard Plan, the Healthy Savings Plan, and the Reimbursement Plan in proportion to each Plan's administrative expenses in the prior fiscal year. Five percent of the amounts forfeited each Fiscal Year will be held as a reserve for one year against reclaimed individual account assets.

You are urged to use your Plan Balance to cover reimbursable expenses without delay. This will help you receive the most benefit from the Plan and avoid or limit the possibility of forfeiture.

If you have any questions regarding the Forfeiture Provisions, your Individual Account, or the Medical Reimbursement Program, please contact the Third-Party Administrator:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563
Toll Free 1-866-263-1185

9. INDIVIDUAL ACCOUNTS

A. Determination of Amount in Individual Accounts

As soon as practicable after each Valuation Date, the Trustees shall calculate and determine the amount in each Participant's Individual Account. The amount in each Individual Account as of the most recent Valuation Date shall be the total of the following:

(1) The amount in the Individual Account as of the last previous Valuation Date, **plus**

(2) The contributions made on behalf of the Participant during the relevant Valuation Period, **minus**

(3) Any transfers to the AGMA Health Fund Standard and Healthy Savings Plans made pursuant to Section 5.A.1 and 5.A.2 since the last preceding Valuation Date, **minus**

(4) Any transfers to the AGMA Health Fund Standard and Healthy Savings Plan, and any transfers to the general assets of the AGMA Health Fund, made pursuant to Section 5.B.2 since the last preceding Valuation Date, **minus**

(5) Any reimbursements for medical expenses or outside health coverage premiums since the last preceding Valuation Date, **minus**

(6) An administrative charge of $5, or the balance of the Individual Account if less, **plus/minus**

(7) The investment return/loss of the Reimbursement Plan allocable to the Individual Account in accordance with Section 9.C if there remains a positive balance after the adjustments set forth in (1) through (3) above, provided however that no investment return credit may be made to an Old Plan Balance in excess of the amount of the administrative charge set forth in (5) below, **minus**

(8) The administrative expense charge as established by the Trustees to be charged to each Individual Account in accordance with Section 9.B, **minus**

(9) Any contributions forfeited pursuant to Section 8.

B. Allocation of Administrative Expenses

At each Valuation Date, the Board of Trustees shall first apply the total amount of administrative charges deducted under Subsection 9(A)(3), above, to pay the Administrative Expenses of the Reimbursement Plan for the preceding quarter. If all the administrative charges deducted under 9(A)(3) are insufficient to pay the Administrative Expenses of the Reimbursement Plan for the preceding quarter, the Board of Trustees shall next deduct a pro rata share of the remaining Administrative Expenses of the Reimbursement Plan for the preceding quarter from each Individual Account.

C. Investment Return

At each Valuation Date, the Board of Trustees shall add to/subtract from each Individual Account with a positive balance a pro rata share of the investment return/losses derived from the change in Fund assets in the preceding quarter, provided however that no investment return credit may be made to an Old Plan Balance in excess of the amount of the administrative charge set forth in 9.B above. Investment Return consists of the net change in the market value of the Fund's invested assets, including interest and dividends.

D. Right to Individual Accounts

The fact that Individual Accounts are established and valued as of each Valuation Date shall not vest in any Participant or others any right, title or interest in the Fund, or in the Individual Account, except to defray the cost of health coverage that a Participant elects to obtain through the AGMA Health Fund Standard or Healthy Savings Plans, or to obtain qualified medical expense reimbursements, including premiums for other health coverage, all to the extent provided for herein.

10. PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Board of Trustees reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized agent(s) of the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Without limiting any other Plan provisions for the discontinuance of coverage, an individual's coverage shall terminate when the Board of Trustees terminates the Plan or when the Plan is terminated for any reason, or when the individual is no longer eligible to receive benefits under the Plan, whichever occurs first.

Neither you, nor your dependents or beneficiaries, nor any other person have or will have a vested or nonforfeitable right to receive benefits under the Plan.

If the Plan is terminated for any reason, any money remaining in the Fund will be used:

- To pay necessary expenses;
- To pay such benefits as the Trustees determine should be paid and for such other purposes that the Trustees decide would best carry out the purposes of the Fund.

No money will revert to the Contributors.

11. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Board of Trustees must honor any "qualified medical child support order" issued by a court or administrative agency which obligates you to pay medical child support and which allocates some portion of your Reimbursement Plan Individual Account to meet these obligations. The Reimbursement Plan will pay such obligations up to the amount in your Individual Account. The procedures used to determine if a medical child support order is qualified are on file at the Third-Party Administrator's office. The procedures are available upon request from the Fund Office.

12. LEAVES OF ABSENCE

A. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth, adoption, or placement with you for adoption or foster care of a child;
- to provide care for a spouse, child, or parent who has a serious health condition;
- your own serious health condition, which prevents you from performing one or more essential functions of your job; or
- qualifying exigencies arising out of the fact that your spouse, son or daughter (of any age), or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

You may be entitled to up to 26 weeks during a 12-month period to take care of a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from serious illness or injuries as a result of their service.

During your FMLA leave, you can continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for a leave under the FMLA if you:

- have worked for a covered employer (Contributor) for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the employer within 75 miles.

If you take an FMLA leave, your Employer is obligated to continue to contribute to the Fund on your behalf. The Fund will accept such contributions and you will be credited with such contributions in accordance with the rules of the Plan. Call your Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

B. MILITARY LEAVE

If you enter military service, you will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. USERRA continuation coverage is a temporary continuation of coverage when it would otherwise end because an employee has been called to active duty in the uniformed services. You must notify the Fund Office as soon as possible but no later than 60 days after the date on which you will lose Plan coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

To continue coverage pursuant to USERRA, you must elect to do so for yourself and any dependents covered under the Plan when the leave started for whom you wish to continue coverage. If your period of military service is more than 31 days, you must pay 102% of the cost of such coverage.

When you are discharged from military service (not less than honorably), eligibility for coverage under the Plan will be reinstated on the day you return to work in Covered Employment, provided you return to employment within certain time

periods specified under USERRA and notify the Fund Office in writing of such return.

Questions regarding continuation and reinstatement of coverage under USERRA should be referred to the Fund Office.

13. BOARD OF TRUSTEES HIPAA STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the privacy rules issued thereunder give you certain rights with respect to your health information, and require the Plan to protect the privacy of your personal health information. A complete description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which is distributed to all Plan participants when they enroll in the Plan and which will be available to anyone upon request from the Office of the AGMA Health Fund (referred to in this section below as the "Fund") or on the website www.agmaretirement-health.org. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan is referred to below as "protected health information." Before the Plan provides your protected health information to the Board of Trustees, the Trustees must certify that the Plan documents have been changed to include the following language.

The Board of Trustees agrees to the following rules in connection with your protected health information:

- The Board of Trustees understands that the Plan will disclose protected health information to the Board of Trustees only for the Trustees' use in plan administration functions.

- Unless it has your written permission, the Board of Trustees will use or disclose that protected health information only for plan administration, or as otherwise permitted by this Summary Plan Description, or as required by law.

- The Board of Trustees will not disclose your protected health information to any of its agents or subcontractors unless the agents and subcontractors agree to handle your protected health information and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.

- The Board of Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

- The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission.

- The Board of Trustees will report to the Plan's Privacy Officer if the Trustees become aware of any use or disclosure of protected health information that is inconsistent with the provisions set forth in this Summary Plan Description.

- The Board of Trustees will allow you, through the Plan, to inspect and photocopy your protected health information, to the extent, and in the manner, required by HIPAA.

- The Board of Trustees will make available to the Plan your protected health information for amendment and incorporation of any such amendments to the extent, and in the manner required by HIPAA.

- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

- The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that it may make available to the Plan the information required for the Plan to provide an accounting of certain types of disclosures of protected health information.

- The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or on behalf the Board of Trustees: The Executive Director, the Assistant to Executive Director (if any), the Fund's IT personnel, and all other Fund claims staff routinely responsible for administration of Plan claims for the Fund. Additionally, the individual Trustees may receive health information from the Plan in the course of hearing appeals or handling other Plan administration functions. These employees and the individual Trustees will be permitted to have access to and use the protected health information only to perform the Plan administration functions that the Board of Trustees provides for the Plan. Separation between the categories of employees listed above and other Fund employees will be supported by reasonable and appropriate security measures.

- The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan's Privacy Offer and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

- The Board of Trustees will return to the Plan or destroy all protected health information received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees will limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

14. COBRA CONTINUATION COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA), requires the Plan to offer each "Qualified Beneficiary" the opportunity for a temporary extension of health care coverage at their own expense under certain circumstances when health care coverage would otherwise end (called "Qualifying Events"). Under the law, Qualified Beneficiaries can include any Employee (i.e., an individual covered by the Plan by virtue of service for a Contributor), Spouse (including, under some circumstances, a former Spouse), or Dependent Child of an Employee who is covered by the Plan when a COBRA-Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA is also a Qualified Beneficiary. A former Spouse may also be a Qualified Beneficiary under some circumstances.

However, a person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/her/theirself. Domestic Partners are not eligible for COBRA Continuation Coverage.

COBRA-Qualifying Events are those shown in the chart below under "COBRA Eligibility and Qualifying Events." Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary under this Plan ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan (e. g. Employee continues working even though entitled to Medicare), then COBRA is not available.

Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

The benefits under COBRA are the same as those for people who are not on Continuation Coverage. You should also keep in mind that each individual entitled to coverage as a result of the Qualifying Event has a right to make their own election of coverage. For example, your Spouse or Dependent Child(ren) may elect COBRA coverage even if you do not.

However, the covered Employee or Spouse is allowed to elect on behalf of any Dependent Children or on behalf of all beneficiaries, and a covered parent or legal guardian may elect on behalf of a minor child.

Under COBRA, you and your Spouse or Dependent Child(ren) may continue the same coverage that you had before the COBRA-Qualifying Event.

COBRA ELIGIBILITY AND QUALIFYING EVENTS

The following chart lists the COBRA-Qualifying Events, who can be a Qualified Beneficiary, and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in weeks worked (making Employee ineligible for health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have dependent status.	N/A	N/A	36 months

[1] *When a covered Employee's Qualifying Event (e.g., termination of employment or reduction in weeks) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Child(ren) who are qualified beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described below). The maximum period of COBRA coverage may be cut short for the reasons described in the subsection on "Early Termination of COBRA Continuation Coverage" that appears later in this section.

COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If you, your Spouse, or any of your covered Dependent Child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the Covered Person who is determined to be entitled to Social Security Disability Income or Supplemental Security Income, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability is deemed by the Social Security Administration to have occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage (or within 60 days of birth or adoption, if the disabled individual is born to or placed for adoption with a covered employee during the covered period);
- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income or Supplemental Security Income from the Social Security Administration (SSA);
- The Plan is notified in writing that the determination was received:
  - No later than 60 days after the Covered Person received the determination; and
  - Before the 18-month COBRA continuation period ends.

The extended period of COBRA coverage due to a disability will end at the earlier of:

- The last day of the month, 30 days after SSA has determined that you and/or your Spouse or Dependent Child(ren) are no longer disabled.
- The end of 29 months from the date of loss of coverage due to the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare benefits.

COST OF COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge members and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period, and for any extension that may apply (up to a maximum of 36 months from the initial qualifying event) based on a second qualifying event occurring during such 11-month extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

HOW COBRA COVERAGE WORKS

Your Employer will usually notify the Fund Office of your death, termination of employment, reduction in weeks, retirement, or enrollment in Medicare benefits (Part A, Part B, or both). However, you or your family must also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification.

In order to have the opportunity to elect COBRA Continuation Coverage after a divorce, legal separation, a child ceasing to be a Dependent Child under the Plan, or a second qualifying event that entitles a Spouse or Dependent Child to additional COBRA coverage, you and/or a family member must notify the Fund Office in writing within 60 days after the occurrence of that event or the loss of coverage resulting from that event, whichever is later.

You must keep the Fund Office apprised of your and any Qualified Beneficiaries' current address(es) and must notify the Fund Office promptly of any changes in your address or the addresses of any Qualified Beneficiaries.

IF WRITTEN NOTICE IS NOT RECEIVED BY THE END OF THE 60-DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT CHILD WILL NOT BE ENTITLED TO CHOOSE COBRA.

PROCEDURES FOR PROVIDING NOTICE TO THE PLAN

You (the Employee) and/or Spouse or Dependent Child must give the Fund Office notice in writing as soon as possible, but no later than the applicable deadline set out above, for the following events:

- a divorce;
- a child ceasing to be a dependent;
- a second qualifying event that entitles a Spouse or Dependent Child to additional COBRA coverage;
- a Spouse or Dependent Child is determined to be disabled by the Social Security Administration;
- a Spouse or Dependent Child who had been determined to be disabled under the Social Security Administration receives notice that he or she is no longer considered disabled.

Please include the following in your notice:

- your name,
- the names of your Spouse or Dependent Child(ren),
- your Social Security number and the Social Security numbers of your Spouse and/or Dependent Child(ren),
- your address, and
- the nature and date of the occurrence you are reporting to the Plan.

That notice should be sent to:

Rhonda Murray
Executive Director
AGMA Health Fund
305 7th Ave., Suite 2B
New York, NY 10001
(212) 765-3664
info@agmafunds.org

The Fund Office will then send you information about COBRA coverage. The Plan must notify you and your Spouse and/or Dependent Child(ren) of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a Qualifying Event has occurred. You will have 60 days to respond if you want to continue coverage—measured from the date coverage would otherwise end, or if later, the date the COBRA notice is sent to you.

HOW TO ELECT COBRA CONTINUATION COVERAGE

When your employment terminates or you experience a reduction in weeks of work so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced or legally separated from your spouse, or that a Dependent Child lost dependent status under the Plan, the Fund Office will give you and/or your covered Spouse and/or Dependent Child(ren) notice of the date on which your coverage ends and the information and forms you and/or they need to elect COBRA Continuation Coverage.

Under the law, you and/or your covered Spouse and/or Dependent Child(ren) will then have 60 days from the date coverage would otherwise end, or if later, the date the COBRA notice is sent to you to elect COBRA.

IF YOU AND/OR ANY OF YOUR SPOUSE AND DEPENDENT CHILD(REN) DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS FROM THE DATE COVERAGE WOULD OTHERWISE END, OR IF LATER, THE DATE THE COBRA NOTICE IS SENT TO YOU, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDED.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more covered dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event (except in the case of newly acquired dependents, as described below). A covered parent or legal guardian may elect or reject COBRA Continuation Coverage on behalf of a minor child.

You may have other options available to you when you lose group health coverage

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. 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. You can learn more about many of these options at www.healthcare.gov.

NOTICE OF UNAVAILABILITY OF COVERAGE

When you, your Spouse, or your covered Dependent Child(ren) have provided notice to the Fund Office of a divorce or legal separation, a Dependent Child ceasing to be eligible for coverage under the Plan, Medicare entitlement and voluntary termination of active coverage, a second qualifying event, or a Social Security disability determination, but you, your Spouse and/or your Dependent Child(ren) are not entitled to COBRA (or an extension of COBRA coverage), the Fund Office will send you a written notice stating the reason(s) why COBRA Coverage is not available. This notice will be provided within 14 days from the day the Fund Office receives Notice of the Qualifying Event.

During the **COBRA** election period, your health coverage under the **Plan** previously covering you will be discontinued until you notify the Fund, on a timely basis, that you elect **COBRA**. Upon such notice, the Fund will reinstate your coverage to the date it had been terminated. If claims are filed on your behalf prior to such notification, they will be denied. However, you can refile them as soon as you have elected your **COBRA** coverage and made payment of the applicable payment on a timely basis.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section entitled "Paying for COBRA Coverage," below, for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Employees and their families, that same change will be made to your COBRA Continuation Coverage.

PAYING FOR COBRA COVERAGE

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, except in cases of extended COBRA coverage due to Social Security disability. See the section entitled "COBRA Coverage in Cases of Social Security Disability" for details. COBRA payments are due on a monthly basis.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Your first payment is due no later than 45 days after the date you elect COBRA coverage. If this payment is not made when due, COBRA Continuation Coverage will not take effect and cannot then be purchased. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. If payment of the amount due is not made by the end of this grace period, your COBRA Coverage will be terminated.

ACQUIRING A NEW DEPENDENT(S) WHILE COVERED BY COBRA

If you, your Spouse, or your Dependent Child(ren) elects COBRA and acquires a new dependent through marriage, birth, adoption or placement for adoption while enrolled in COBRA Continuation Coverage, that person may add the dependent to COBRA Coverage for the balance of the COBRA Coverage period. For example, if you have five months of COBRA left and you get married, you can Enroll your new Spouse for five months of COBRA Coverage.

To Enroll your new dependent in COBRA Coverage, you must notify the Fund Office within 31 days after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA Coverage ceases for you, your Spouse or your Dependent Child(ren) before the end of the maximum 18, 29, or 36-month COBRA Coverage period, COBRA coverage also will end for the newly added dependent. However, COBRA Coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA Coverage period if the required premiums are paid on time. Check with the Fund Office for more details on how long COBRA Coverage can last.

LOSS OF OTHER GROUP HEALTH PLAN COVERAGE OR OTHER HEALTH COVERAGE

If, while you are enrolled in COBRA Continuation Coverage, your Spouse or Dependent Child(ren) loses coverage under another group health plan, you may Enroll the Spouse or Dependent Child(ren) for coverage for the balance of the period of COBRA Continuation Coverage.

You must Enroll the dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

MULTIPLE QUALIFYING EVENTS WHILE COVERED BY COBRA

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. More specifically, if, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in weeks (or during any 11-month extension of such period based on a Social Security disability determination), you die, divorce or legally separate from your spouse, or become enrolled in Medicare benefits (Part A, Part B, or both), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or Dependent Child may be extended to up to 36 months from the date of loss of coverage due to the occurrence of your termination of employment or reduction of weeks. 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.

For example, assume you lose your job (the first COBRA-Qualifying Event), and you enroll yourself and your Spouse and Dependent Child(ren) for COBRA coverage. Three months after your COBRA coverage begins, you divorce and your former Spouse is no longer eligible for Plan coverage. Your former Spouse can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after your loss of coverage due to the termination of employment or reduction of weeks. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active member) during the 18-month period of COBRA Continuation Coverage (or the 29-month period in the case of a Social Security disability extension).

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in weeks (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability).

As a result, if you experience a reduction of weeks and then have a termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the date of loss of coverage due to the occurrence of the initial Qualifying Event.

TERMINATION OF EMPLOYMENT/REDUCTION OF WEEKS FOLLOWING MEDICARE ENROLLMENT

If you become enrolled in Medicare benefits (Part A, Part B, or both) and you later have a termination of employment or reduction of weeks, then you, your Spouse and/or your Dependent Child(ren) would be entitled to COBRA Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of weeks or 36 months from the date you become enrolled in Medicare (Part A, Part B, or both), whichever is longer.

FMLA AND COBRA

Taking a leave under the Family and Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur after the FMLA period expires, if the person does not return to work and thus loses coverage under the group health plan. Then the COBRA period is measured from the date of the Qualifying Event – in most cases, the last day of the FMLA leave. Note that if the Employee notifies the Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

ALTERNATIVE COVERAGE AND COBRA

If, after a Qualifying Event, a Qualified Beneficiary is provided with alternative health coverage without regard to the availability of COBRA coverage under this Plan (for example, as a result of the Uniformed Services Employment and Reemployment Rights Act) and this alternative coverage is not identical in cost or benefits to the COBRA coverage, then the Qualified Beneficiary must be offered COBRA under this Plan. If an individual rejects the COBRA coverage in favor of the alternative coverage, then, after expiration of the alternative coverage period, no COBRA offering is required under this Plan.

WHEN COBRA COVERAGE WILL END PRIOR TO THE APPLICABLE 18, 29 OR 36 MONTHS

Once COBRA coverage has been elected, it will end prior to the applicable 18, 29 or 36 months on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your Spouse or Dependent Child(ren) first become covered by another group health plan (other than the AGMA Health Fund Standard or Healthy Savings Plans).
- The date, after the date of the COBRA election, on which you or your Spouse or Dependent Child(ren) first become enrolled in Medicare benefits (Part A, Part B, or both), usually age 65.
- If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed no longer disabled by SSA.

NOTICE OF EARLY TERMINATION OF COBRA

If COBRA Continuation Coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the determination that Continuation Coverage will terminate. The notice will set out why COBRA Continuation Coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

WHEN COBRA COVERAGE ENDS

Your COBRA Coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) applicable to you and/or your dependents ends.

Full details of COBRA Continuation Coverage will be furnished to you, your Spouse, or your Dependent Child(ren) when the Fund Office receives notice that a Qualifying Event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

15. ADMINISTRATIVE INFORMATION

Plan Name:	AGMA Health Fund Reimbursement Plan
Employer Identification Number:	13-6701211
Plan Number:	501
Fiscal Year End:	August 31
Plan Year:	September 1 - August 31

The Plan is a group health and welfare plan. A joint Board of Trustees, consisting of an equal number of Contributor and AGMA representatives is the "Plan Administrator." The Board of Trustees has been designated as the agent for the service of legal process. Service of legal process may be made upon the Executive Director, on behalf of the Board of Trustees, at the Fund Office address:

AGMA Health Fund Reimbursement Plan
305 7th Ave., Suite 2B
New York, NY 10001

All contributions to the Plan are made in accordance with collective bargaining or other agreements with AGMA. The Third-Party Administrator will provide you, upon written request, with information as to whether a particular company or organization is a contributor to this Plan on behalf of Participants working under an agreement. If you request in writing, the Third-Party Administrator will also provide you with a copy of the agreements or make them available for examination by Participants. Benefits are provided from the Plan's assets, which consist of contributions paid under the provisions of the collective bargaining agreements and investment earnings thereon, and are held in a trust fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses of the Reimbursement Plan.

The Plan's assets consist of U.S. Fixed Income Securities and U.S. and International Equity Investments that are managed and held in custody by a professional investment firm.

The Plan shall be administered and operated by the Plan Administrator, in its sole and absolute discretion. The Plan Administrator, and any duly authorized representative thereof, shall have the complete authority to administer, apply and interpret the Plan (and any related documents) and to decide all matters arising in connection with the operation or administration of the Plan. All determinations made by the Plan Administrator with respect to any matter arising under the Plan (and any other Plan document) shall be final, conclusive and binding on all parties.

16. ADDITIONAL NOTICES

A. ERISA RIGHTS

As a participant in the AGMA Health Fund Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500
   Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.
2. No one, including your employer, your union (AGMA), or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, as discussed in the Claims and Appeals Procedures section of this document.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Claims and Appeals section of this document on the requirement to appeal a denied claim before filing a lawsuit.
4. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

5. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
6. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

B. ADDITIONAL NOTICES

Although the Plan only provides reimbursement benefits as described above, and does not provide direct coverage of maternity or mastectomy-related care, group health plans including the Plan are generally required to provide the following notices concerning such care:

Maternity Care
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mastectomy-Related Care
Under the Women's Health and Cancer Rights Act of 1998, if you or your covered dependent is receiving benefits in connection with a mastectomy, and you elect breast reconstruction in connection with the mastectomy, you are entitled to coverage for the following:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

AGMA HEALTH FUND
REIMBURSEMENT PLAN

Administered by:

Administrative Services Only, Inc.
PO Box 9010
303 Merrick Road, Suite 300
Lynbrook, New York 11563-9010

1-866-263-1185 www.asonet.com