HOUSE STAFF BENEFITS PLAN

SUMMARY OF MATERIAL MODIFICATION #1
HOUSE STAFF BENEFITS PLAN 2024 SPD
PLEASE READ NOW!

May 29th 2026

This notice contains important information regarding changes to the 2024 House Staff Benefits Plan (the "Plan" or "HSBP") Summary Plan Description ("SPD"). **This Summary of Material Modifications ("SMM") is issued to notify you of changes and improvements to your dental, supplement dental, and vision benefits effective July 1, 2026.**

With regard to Dental Benefits, the Plan has eliminated the Managed DentalGuard option, and all participants will be automatically enrolled in the more generous Guardian's DentalGuard Preferred plan effective July 1, 2026, which is a Preferred Provider Organization that also covers services provided by out-of-network providers. Guardian will still administer the benefits, so you will still use Guardian's network to find Preferred Providers.

With regard to Vision Benefits, the Plan has improved the level of benefits provided by Davis Vision, added coverage for contact lens exams, and has expanded the list of in-network providers to include Warby Parker, Target, and Walmart.

Please take the time to read this notice carefully and share it with your covered family members. Keep this notice with your Plan documents.

1. **The Plan's in-network provider list for Vision benefits has been expanded to include Warby Parker, Target, and Walmart.**

2. **The "In-Network Benefit" subsection under *Vision Benefit*, on page 63 of the SPD, and the charts, on pages 65-66 of the SPD, are deleted in their entirety and replaced as follows:**

   <u>In-Network Benefit</u>

   The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependent(s) use your benefit In-Network you will be entitled to the following benefits:

   - Free eye exam every Plan Year (July 1 to June 30) (includes dilation when professionally indicated);
   - Spectacle Lenses every Plan Year (see chart below for lens options and co-pay amounts);

- Frames every Plan Year as follows:
    - Any frame from the Davis Vision Fashion, Designer, or Premier Collection will be covered in full (retail value, up to $225) with no copayment; OR
    - If you choose a frame that is NOT in the Davis Vision Collection, you will receive a $130 allowance toward any frame from the participating provider plus 20% off any balance with no copayment.*
- Contact Lenses every Plan Year (in lieu of eyeglasses):
    - Any contact lenses from the Davis Vision Collection are covered in full, including up to two boxes/multipacks for planned replacement contact lenses or four boxes/multipacks for disposable contact lenses; OR
    - If you choose contact lenses that are NOT in the Davis Vision Collection, you will receive a $130 allowance plus 15% off any balance with no copayment*; OR
    - If you choose visually required contacts, they will be covered up to $210 with prior approval.

  *Some limitations apply to additional discounts; discounts not applicable at all in-network providers

Contact Lenses

If you require a contact lens evaluation, fitting, and follow up care, it will be covered in full with no copayment. This includes Davis Vision Collection contacts, non-Collection standard contacts, and non-Collection specialty contacts**.

**Including, but not limited to toric, multifocal, and gas permeable contact lenses.

Copayments

Lens Types and Coatings	Copay
Clear Plastic Lenses (single, bifocal, trifocal, or lenticular)	$0
Scratch Resistant Coating	$0
Premium Scratch Resistant Coating	$30
Tinting of Plastic Lenses	$0
Polycarbonate Lenses	$0
Ultraviolet Coating	$0
Standard Progressives	$0
Premium Progressives	$40
Ultra Progressives	$90
Ultimate Progressives	$125
Plastic Photosensitive Lenses	$65
Digital Single Vision Lenses	$0
Polarized Lenses	$75
Standard Anti-Reflective (AR) Coating	$35

Premium AR Coating	$48
Ultra AR Coating	$60
Ultimate AR Coating	$85
High-Index Lenses 1.67	$55
High-Index Lenses 1.74	$120
Scratch Protection Plan Single Vision	$20
Scratch Protection Plan Multifocal Lenses	$40
Trivex Lenses	$50
Blue Light Filtering	$15

3. **The "Out-of-Network Benefit" subsection under *Vision Benefit* on page 64 of the SPD is amended to update the claims mailing address as follows:**

   Mail claims to:

   Vision Care Processing Unit
   P.O. Box 479
   Troy, NY 12181

4. **The "Other Vision Benefits" subsection under *Vision Benefit* on page 63 of the SPD is deleted and replaced with the following:**

   Mail Order Contacts: You can purchase contact lenses online through available in-network or out-of-network providers. Please refer to the "In-Network Benefit" and "Out-of-Network Benefit" subsections for applicable cost-sharing.

   One Year Breakage: Warranty Repair or replacement of your plan-covered spectacle lenses, collection frame or frame from an In-Network retail location where the Collection is still available. If your selected lenses, Collection frame, or frame is not available, Davis Vision will replace with another item from the same tier.

   Additional Savings: Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount (some limitations apply to additional discounts; discounts not applicable at all in-network providers).

   Laser Vision correction: Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisionvision.com.

   Low Vision Services: Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

5. **The "Appealing Vision Coverage" subsection under *Vision Benefit* on page 67 of the SPD is amended to update the contact information and claims filing address:**

   Call Davis Vision, (800) 999-5431 for more information. Email your complaint, grievance or appeal to RTQA@versanthealth.com, or address it to:

   Davis Vision Inc.
   Attention: Quality Assurance/Patient Advocate Department
   PO Box 547
   Troy, NY 12181

6. **The Dental benefit information described under the General Benefits Summary on page 3 of the SPD is amended to read as follows:**

Benefit	Insurer	Contact	Other Important Documents Incorporated into this SPD
Dental	HSBP (administered by Guardian)	Guardian Dental Group #417732 www.guardianlife.com (800) 541-7846	N/A

7. **The *Dental Benefits* section on pages 19-28 of the SPD is deleted in its entirety and replaced as follows:**

DENTAL BENEFITS

(Insured by the Plan; administered by Guardian) – Group #417732

Dependent(s) Covered Up To Age 29

Child(ren) will be covered up to the end of the calendar year of their 29th birthday.

DENTALGUARD PREFERRED (DGP)

DGP is a Preferred Provider Organization (PPO) which allows the member and eligible dependent(s) greater freedom in choice of dentists. DGP is designed to provide high quality dental care while controlling the cost of such care. To do this, DGP encourages you or your dependent to seek dental care from dentists and dental care facilities that are under contract with Guardian's PPO.

The Plan usually pays a higher payment for benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a non-preferred, out-of-network provider.

Guardian's PPO network is made up of Preferred Providers in you or your dependent's geographic area. Use of Guardian's PPO network is voluntary, and you (or your dependent) may receive dental treatment from any dental provider you choose on an out-of-network basis. And you are free to change providers anytime.

Upon enrollment, you (and your dependent(s)) will be able to download your dental plan ID card and find a list of Preferred Providers on www.GuardianLife.com under "find a dentist." You may also download the Guardian Anytime app for your ID card and a list of current Preferred Providers:


Download for iOS


Download for Android

You (or your dependent) must present their ID card when you use a Preferred Provider. Most Preferred Providers prepare necessary claim forms for you or your dependent and submit the forms to Guardian. Guardian sends you or your dependent an explanation of benefits, but any benefit payable is sent directly to the Preferred Provider.

What the Plan pays on your behalf is based on the terms of DGP. Please read this document carefully for specific benefit levels, Deductibles, payment rates and payment limits.

Call Guardian at the number shown on your ID card with any questions.

Covered Charges

To be covered by DGP, a service must be: (a) necessary; and (b) included in the List of Covered Dental Services. Guardian may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

The Plan pays both Preferred Providers and non-preferred, out-of-network Providers according to DGP's negotiated fee schedule established with its contracted dentist network.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this dental plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planning. If the scaling and root planting is performed one or two weeks prior to the osseous surgery, Guardian may only pay benefits for the osseous surgery.

Alternate Treatment: If more than one type of service can be used to treat a dental condition, Guardian has the right to base benefits on the least expensive service which is within the range

of professionally accepted standards of dental practice as determined by Guardian. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

The Plan only pays benefits for covered charges incurred by you (or your dependent) while you are insured by DGP. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while you (or your dependent) is insured, the Plan will only pay benefits for services which are completed within 31 days of the date your coverage under DGP ends.

LIST OF COVERED DENTAL SERVICES† UNDER DENTALGUARD PREFERRED		
	Preferred Provider	**Non-Preferred, Out-of-Network Provider**
Plan Year Deductible	$0	$25 (3/family; waived for preventive services)
Plan Year Payment Limit (excluding Orthodontia)	Up to $2,000 plus Maximum Rollover (see below)	
Preventive Services		
Includes oral exams (once/6 mos.); cleanings (once/6 mos.*); x-rays (full mouth series, once/60 mos.); fluoride treatment (to age 14, once/6 mos.); sealants (to age 16, once/36 mos.); and space maintainers/harmful habit appliances	100%	100%+
Basic Services		
Includes fillings**; perio maintenance procedure (once/6 mos.*); periodontal services (e.g., scaling and root planning);	100%	100%+

periodontal surgery; simple extractions; complex extractions; endodontic services (e.g., root canal); repair and maintenance of crowns, bridges, and dentures; and general anesthesia***		
Major Services		
Includes bridges[x] and dentures; single crowns[x]; inlays, onlays, and veneers; prothesis which replaces a tooth or teeth lost or extracted before being covered by this Plan	60%	60%[+]
Orthodontia		
Orthodontia	60% for Adult and Child Orthodontics (orthodontia in progress is covered)	
Orthodontia Services Lifetime Maximum	$1,800	$1,800

[†] Services subject to change.
[+] Subject to balance billing.
* Limited to a total of one cleaning or one perio maintenance procedure in any six-consecutive-month period
** Fillings are covered one (1) time per tooth every 12 months under age 19 and one (1) time per tooth every 36 months age 19 and older.
*** Anesthesia is only available when administered with covered surgical services.
[x] Replacement limited to every ten (10) years.

Maximum Rollover Account

With Maximum Rollover, Guardian will rollover a portion of your or your dependent's unused Plan Year Maximum into your or your dependent's Maximum Rollover Account (MRA). The MRA can be used in future Plan Years towards non-Orthodontic Services after you have exhausted the Plan Year Maximum.

Guardian will roll over $400 for every Plan Year that the Plan paid dental claims less than $800 per insured individual. However, if you or your dependent have services exclusively rendered by DentalGuard Preferred Providers, the amount rolled over will increase to $600. If your claims are more than $800 for the Plan Year, Guardian will not roll over any funds.

If you have less than $800 worth of claims in a Plan Year, Guardian will rollover the $400 (or $600), until you have up to $1,500 in your account.

To qualify, you must submit a claim (and not just have a visit) and not exceed the $800 threshold during the Plan Year. You and each of your insured dependent(s) maintain separate

MRAs based on your own claim activity. Guardian will only rollover up to a cumulative maximum amount of $1,500 into each MRA.

Type of Provider	Max Claims Paid by Plan	Amount Rollover to the Next Plan Year	Max Amount Allowed in MRA
Only DentalGuard Preferred Providers	$800	$600	$1,500
Non-Preferred, Out-of-Network Provider	$800	$400	$1,500

- An employee joining the plan as a new hire with 3 months or less remaining in the Plan Year: the MRA accumulation will begin as of the first full Plan Year. (Example: for an Employee joining in May of 2026, claim activity between July 1, 2026 and June 30, 2027 will be used and applied to their MRA for use in the Plan Year between July 1, 2027 and June 30, 2028).

Out-of-Pocket Charges

Guardian will be paid for services only up to the maximum negotiated fee schedule established with its contracted network dentists. Any amount that is charged over the fee schedule is your responsibility, and out-of-network Providers may balance bill for the difference.

How Much Do I Owe Before the Services are Rendered?

Pre-treatment Review: Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300.

- Have your dentist fax your treatment plan to Guardian, note that it is a pre-treatment review and Guardian will let your dentist know what benefits would be payable.

General Limitations and Exclusions

Plan coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles, frequency limitations, and payment limits may apply.

The Plan does not pay for:

- oral hygiene services (except as covered under preventive services);
- Any restoration procedure, appliance or dental prosthesis used solely to: a) alter vertical dimension; b) restore or maintain occlusion, except to the extent that this plan

covers orthodontic treatment; c) splint or stabilize teeth for periodontal reasons; or d) treat a condition caused by abrasion or attrition;

- Cosmetic or experimental treatments unless listed in this *Dental Benefits* section;
- Replacing a lost, stolen or missing appliance or prosthetic device; or making a spare appliance or device;
- Treatment needed due to: a) an on-the-job or job-related injury; or b) a condition for which benefits are payable by Workers' Compensation or similar laws;
- Treatment for which no charge is made;
- Replacing an appliance or prosthetic devices with a like appliance or device, unless: a) it is damaged while in the covered person's mouth in an injury suffered while insured, and cannot be fixed; and b) cannot be made usable and meets the replacement age criteria of this plan;
- The replacement of extracted or missing third molars/wisdom teeth;
- Treatment of congenital or developmental malformations;
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations;
- Any procedure performed in conjunction with, as part of, or related to a non-covered procedure; and
- Any procedure not specifically listed as a covered benefit.

Note: Additional exclusions may apply. For additional information, call Guardian Member Services at (800) 541-7846.

DENTAL CLAIMS AND APPEALS

DENTAL CLAIMS

You (or your dependent) must present your dental ID card when you use a Preferred Provider. Most Preferred Providers prepare necessary claim forms for you or your dependent and submit the forms to Guardian. If the Preferred Provider does not submit a claim form, or you use a non-preferred, Out-of-Network provider, you must submit a claim form to Guardian within fifteen (15) months from the date of service.

You can find the reimbursement claim form for Guardian dental benefits on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. Claim forms are also available at www.guardianlife.com.

When filing your claim, you will need to provide specific information regarding the services provided, including, but not limited to, data, tooth number(s) or letter(s), and procedure and diagnosis code(s). Guardian reserves the right to request additional information in its

discretion, including radiographs, charting, or other diagnostic materials that document and support the necessity of the treatment.

Fax your claim to (509) 468-4590, or mail it to:

Guardian Dental Claims
PO Box 981572
El Paso, TX 79998-1572

For more information about filing a claim, call Guardian at (800) 541-7846.

Guardian's Review

Guardian will provide a benefit determination to you not later than 30 days after receipt of a post-service claim. If you fail to provide all information needed to make a benefit determination, Guardian will notify you of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim. The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond its control, and so notifies you before the end of the initial 30-day period. If Guardian extends the time period for making a benefit determination due to your failure to submit information necessary to decide the claim, you will be given at least 45 days to provide the requested information. The extension period will begin on the date on which you respond to the request for additional information.

DENTAL APPEALS

If your claim is denied, Guardian will provide a notice to you that will set forth:

- The specific reason for the adverse benefit determination;
- A reference to the specific plan provision(s) on which the determination was based;
- A description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- A description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action following a final adverse benefit determination;
- Identification and a description of any internal rule, guideline or protocol relied upon in making the determination, or a statement that a copy of such information will be provided to you upon request;
- In the case of a determination based on medical necessity or experimental or investigational treatment, the notice will either include an explanation of the scientific or clinical basis for the determination or explain how you may obtain it free of charge upon request; and

- If your claim was urgent, a description of the expedited review process.

Appeals for dental benefits must be directed to Guardian in writing. **Your request for review must be made in writing within 180 days after you receive notice of denial.** You should include all relevant materials and information, including materials and information from your provider. For the services listed below, you must include the required material listed below:

Appeal Documentation Requirements

Service	Code	Required Material
Inlay/Onlay Crown Crown buildup Post and core Veneer Gingival flap Crown lengthening Bone graft Guided tissue regeneration Abutment crowns Surgical extraction Bone replacement graft	2500 - 2699 2700 - 2799 2950, 6973 2952, 2954, 6970, 6972, 6976 6979 2960, 2962 4240, 4241 4249 4263, 4264 4266, 4267 6700 - 6799 7210 7953	Radiographic image (X-ray)
Osseous surgery Root planning and scaling	4260, 4261 4341, 4342	Radiographic image (X-ray) and Periodontal charting
Tissue graft	4270, 4271, 4273, 4275, 4276	Periodontal charting

For more information about filing an appeal, or if your appeal involves an urgent care claim, call Guardian Member Services at (800) 541-7846.

Filing an Appeal

There are three ways to file an appeal:

- File on the GuardianLife.com website:
  https://www.guardiananytime.com/securechannel/contactus

- Mail to:
  Guardian Dental PPO Claims Appeals
  Attn: Appeals Department
  PO Box 981572
  El Paso, TX 79998-1572

- Fax to: (509) 468-6356

DENTAL COORDINATION OF BENEFITS

Who Pays First When You're Covered By More Than One Plan

Because you and any dependents covered by the HSBP dental plan may have other dental coverage, Guardian will need to determine which plan is responsible for paying first. Guardian will coordinate benefits with other plans, so the total amount of benefits paid doesn't exceed the allowable amount for the services received.

The HSBP dental plan will pay any benefits available for the covered services you receive before any other dental plan.

For covered services your spouse receives, the plan that will pay any benefits available first will be:

- Your spouse's plan if your spouse is covered as an active employee.
- The plan that's been in place the longest if the above rule doesn't apply.

For covered services your child receives, the plan that will pay any benefits available first will be:

- The plan of the parent whose birthday is earlier in the year.

For a child whose parents are separated and not living together:

- In an equal custody split, the plan of the parent whose birthday is earlier in the year.
- The plan identified by any applicable court order.

If there isn't a court order that says which plan pays first, the dental services will be paid in the following order:

- The plan of a biological parent with custody pays first.
- The plan of a stepparent with custody pays second.
- The plan of a biological parent without custody pays third.
- The plan of a stepparent without custody pays fourth.

Coordinating Benefits

When the HSBP dental plan pays benefits first, Guardian will calculate the benefits payable as if you have no other dental coverage. When another plan pays benefits first, the benefits available under the HSBP dental plan will be calculated so that the total amount of benefits paid between all

of your plans combined doesn't exceed the allowable amount for the services received. Guardian also won't pay more in benefits than Guardian would pay if the HSBP dental plan paid first.

A dentist that is in a network has agreed to charge a certain amount for specific dental services. These amounts are listed in a fee schedule. Guardian will apply the following rules when determining the benefits available:

- When both plans use a fee schedule, the schedule allowing the higher fee will be used.
- When the plan that pays first is the only plan that uses a fee schedule, that plan's fee schedule will be used.
- When another plan pays first and doesn't use a fee schedule, the fee schedule for the HSBP dental plan will be used.
- When neither plan uses a fee schedule, the highest allowable amount offered by either plan will be used.

8. The following subsections under the *Claims Review and Appeal Procedure* section on pages 71-73 of the SPD are deleted and replaced as follows:

Request for Review of Disputed Claims

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a request for review of the disposition of your claim or adverse benefit determination regarding your claim:

- *Requests for review of Guardian Long-Term Disability claims must be made within 180 days of Guardian's adverse benefit determination (see below).*
- *Requests for review of Guardian Dental claims must be made within 180 days of Guardian's adverse benefit determination (see below).*
- *Requests for review of Guardian Life Insurance claims must be made within sixty (60) days of Guardian's adverse benefit determination (see below).*
- *Requests for review of Davis Vision claims must be made within 180 days of Davis Vision's adverse benefit determination (see below).*

***For requests for review of all other benefits**, your request for review must be made in writing within 180 days of written notice of the Plan's adverse benefit determination. Mail your request for review to the Board of Trustees of HSBP at 10-27 46th Avenue, Suite 300-2, Long Island City, New York 11101, or email your appeal to benefits@cirseiu.org.*

You will be notified, in writing, of the decision of the Board of Trustees within sixty (60) days (forty-five (45) days for disability claims) of the date your request for review is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within 120 days (ninety (90) days for disability claims). The decision will include the

specific reason(s) for the decision and specific reference(s) to the plan provisions on which the decision is based.

Requests for Review of Guardian Dental Claims (Group #417732)

You must submit your request for review of your claim in writing **within 180 days of Guardian's adverse benefit determination**. Call Guardian Member Services at (800) 541-7846 for more information.

There are three ways to file an appeal:

- Mail to:

  Guardian Dental PPO Claims Appeals
  Attention: Appeals Department
  PO Box 981572
  El Paso, TX 7998-1572

- File on the GuardianLife.com website:
  https://www.guardiananytime.com/securechannel/contactus

- Fax to: (509) 468-6356

Requests for Review of Davis Vision Claims (Client Code 2200)

Appeals for vision benefits must be directed to Davis Vision. Your request for review must be made in writing **within 180 days** after you receive notice of denial. Call Davis Vision at (800) 999-5431 for more information.

Email your complaint, grievance or appeal to RTQA@versanthealth.com, or mail it to:

Davis Vision Inc.
Attention: Quality Assurance/Patient Advocate Department
PO Box 547
Troy, NY 12181

In all communications about a claim, be sure to include your identification number and group number.

9. The *Coordination of Benefits* section on pages 75-79 of the SPD is amended to read as follows:

COORDINATION OF BENEFITS

Purpose
When a covered person has health care coverage under more than one plan, this section allows HSBP to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than they incur in charges.

Definitions

Allowable Expense
This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

- If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim
This term means a request that benefits of a plan be provided or paid.

Claim Determination Period
This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination of Benefits
This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent
This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan
This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual

mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school accident type coverage or such coverage issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description. Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan
This term means a plan that is not a primary plan.

This Plan
This term means the benefits provided under the HSBP.

Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Order in which HSBP will Coordinate:
The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

The plan that covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan that covers the person as a dependent of a person whose birthday comes later in that calendar year.

If items 1 and 2 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed primary and will pay its benefits first, except that the benefits of a plan which covers the person as a retired employee or the dependent of such person shall be determined after the benefits (that is, as a secondary plan) of any other plan which covers such person as an employee who is not retired or a dependent of such person. If either plan does not have a provision regarding retired employees and as a result each plan determines its benefits after the other, then the preceding sentence will not apply.

Coordination of Benefits with Medicare
If you or your spouse is age 65 or older, you are eligible for Medicare even if you are not retired. Medicare includes hospital insurance benefits (Part A), other medical insurance (Part B), and prescription drug benefits (Part D).

As stated above, the plan that covers the person other than as a dependent (for example, as an employee or member) is primary and the plan that covers the person as a dependent is secondary. However, if a person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent and primary to the plan that covers the person other than as a dependent (for example, a retiree), then the order of payment between the two plans is reversed so that the plan that covers the person as an employee or member, etc., is secondary and the other plan covering the person as a dependent is primary. Note that special rules apply if you or your dependent are entitled to Medicare because of End Stage Renal Disease or disability. Contact the Benefits Office at (212) 356-8180 for more information.

Child Covered under more than One Plan
The order of benefit determination when a child is covered by more than one plan is:

> If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
>
> If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
>
> In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active or Inactive Employee
The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not

have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage
The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length of Coverage
The plan that covered the person longer is primary.

Other
If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But this plan will not pay more than it would have had it been the primary plan.

Effect on the Benefits of this Plan

When This Plan Is Primary
When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

10. The *Supplemental Dental Benefit* section on pages 37-38 of the SPD is deleted in its entirety and replaced as follows:

SUPPLEMENTAL DENTAL BENEFIT – $1,000 (PER PERSON)

(Insured by HSBP)

The maximum benefit is $1,000 per person per Plan Year.

If you or your eligible dependent is enrolled in Guardian DentalGuard Preferred or another dental plan, such as the spouse's ("Dental Plan"), this supplemental benefit will reimburse 100% of the coinsurance and copayment amounts paid by the employee and/or dependent for covered services. This 100% supplemental reimbursement will **not exceed the maximum per person per Plan Year of $1,000**. **Only services that are covered by your Dental Plan will be reimbursed by HSBP. Plan reimbursement will not exceed the employee or dependent's out-of-pocket costs.** Insurance deductibles paid under your primary dental plan (if any) are **not** reimbursable under this benefit.

For Example:

Amount of Dental Service Charged to Your Primary Dental Plan	Maximum Primary Plan Allowance	Amount Your Primary Plan Pays	Amount You Owe (Coinsurance or Copayment)	HSBP's Supplemental Reimbursement to You
$2,170	$875	$748.85	$126.15	$126.15

With your Dental Reimbursement Claim Form**,** you **must** attach the Explanation of Benefits (EOB) received from the Dental Plan **and** receipts showing proof of payment and date of service.

How to Make a Claim

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

If you are enrolled in Guardian DGP Plan or another dental plan, you **must** attach the Explanation of Benefits (EOB) received from the plan **and** receipts showing proof of payment and date of service.

The entire claim form must be completed in full by you or your dependent.

Reimbursements will be made only for services that are covered by Guardian or the other dental plan.

A separate claim form must be submitted per patient.

All claims must be submitted to our office within one year from the date of service; claims submitted after one year will be denied.

11. A new section, *Third Party Liability*, shall be added before the *Notice of Electronic Disclosure* section on page 80 of the SPD that states as follows:

THIRD PARTY LIABILITY

Subrogation

If you or any person covered by HSBP as your beneficiary (hereinafter "You" or "covered individual") should suffer an illness or injury, or require medical treatment through the act or omission of someone else or for which a third party may be legally responsible, for which benefits under HSBP's coverage is payable, the following subrogation provisions will apply. If this illness or injury is the result of an accident for which payment may be available from another source, a claim may be submitted for these expenses and payment considered by the Trustees. It is possible that HSBP may advance benefit payment in order to assist you in your time of need. HSBP will have the right to recover any paid benefits from the responsible party. You are required to notify HSBP promptly of any third-party claim you may have for an injury or illness for which HSBP has paid or may pay benefits and any demand made or suit filed against any third party.

In addition, HSBP will have the right to recover any payments which were made to a covered individual and which caused a duplicate payment for the same expenses. The covered individual will cooperate with and assist HSBP in recovering any benefits for which other payment is available and to notify HSBP promptly of any third-party recovery, whether in or out of court, that you, your dependent, or your parents or any agent, representative or trustee or any of them obtains.

The covered individual must reimburse HSBP promptly out of any recovery from any source, including the third party or the third party's insurer, for the benefits paid to the covered individual. HSBP's right to subrogation and reimbursement applies to all rights of recovery

of the covered individual and the covered individual's dependents, parents, representative, guardian or trustee, regardless of whether the recovery fully compensates the covered individual for the loss. Acceptance of benefits from HSBP automatically assigns to HSBP any rights to recovery of duplicate payments. HSBP has a constructive trust and an equitable right to and lien with regard to any monies received by an employee or dependent and/or his or her attorney or representative from a third party to the extent of benefits as described above. You must forward any recovery to HSBP within ten (10) days of receipt or notify HSBP why you are unable to do so.

HSBP must be reimbursed in full up to the total amount of all benefits paid by HSBP in connection with the injury or illness from any recovery you receive from a third party, as well any first-party coverage, including, but not limited to, any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, school insurance or workers' compensation insurance, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party or first-party coverage (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse HSBP for benefits paid. In the event you receive an award for future medical expenses, HSBP will not pay any benefits until you demonstrate that the full award of future medical benefits has been used to treat the injury or illness. HSBP has the right of first reimbursement on a priority first-dollar basis out of any recovery obtained, even if you are not fully compensated (or "made whole") for your loss, and HSBP's claim has first priority over all other claims and rights.

Neither you nor your dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries for which benefits were paid by HSBP. The Trustees strongly recommend, however, that if you are injured as a result of the negligence or wrongful act of a third party, you should contact an attorney for advice and counsel. HSBP cannot and does not pay for the legal fees your attorney may charge.

HSBP's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of HSBP's claim is subject to prior written approval by the Trustees in their sole discretion.

If you choose not to pursue the liability of a third party, HSBP will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with HSBP with respect to any attempt to recover HSBP benefits payable to you or your eligible dependent related to an injury or illness caused by the act or omission of a third party.

Note that other provisions of HSBP may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g., Workers' Compensation cases, certain automobile accidents, etc.). Please review carefully the specific limitations and exclusions in this SPD.

Please contact us if you have questions.

Sincerely,

CIR BENEFIT FUNDS